I. Severability. If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

J. Waiver. None of the terms of this Agreement shall be deemed to be waived by either party, unless such waiver be in writing and duly executed on behalf of the party to be charged with such waiver by its authorized officer and unless such waiver recites specifically that it is a waiver of the terms of this Agreement. The failure of either party to insist strictly on any of the terms or provisions of this Agreement shall not be deemed a waiver of any subsequent breach or default of its terms or provisions.

K. Applicable Law. This Agreement shall be governed by and interpreted and enforced in accordance with the internal laws of the State of Indiana. The parties hereby irrevocably and unconditionally consent to the exclusive jurisdiction of the courts of the State of Indiana and of the United States of America located in Marion County, Indiana (the "Indiana Courts") for any litigation arising out of or relating to this Agreement (and agree not to commence any litigation relating to this Agreement except in such Indiana Courts) and waive any objection to venue of any such litigation in the Indiana Courts.

L. Assignment. Except as otherwise provided herein, any assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party.

M. Notice. Any notice required or permitted by this Agreement shall be in writing and shall be deemed delivered three (3) days after it is deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, addressed to the party to whom it is to be given as follows:

BLOOD CENTER: Indiana Blood Center
Byron B Buhner, President and CEO
3450 North Meridian Street
Indianapolis, IN 46208

cc: Mike Parejko, Executive VP/COO

CLIENT: Community Hospital East
Robin Ledyard, MD, President
1500 Ritter Avenue
Indianapolis, IN 46219

N. Entire Agreement. This agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings whether written or otherwise between the parties relating to the subject matter hereof. There exists no

other understandings, terms or conditions, written or oral, related to the rights and obligations established by this Agreement, and neither Party has relied on any representation, express or implied, not contained herein.

O. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

P. Amendments. This Agreement may only be modified or amended if the amendment or modification is made in writing and is signed by both parties.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Client and the Blood Center have duly executed this Agreement on the date first written above.

"Blood Center"
Indiana Blood Center

By: Byron B Buhner
Byron B. Buhner, President and CEO

6-27-13
Date

"Client"
Community Hospital East

By:
Robin Ledyard, MD, President

8-19-2013
Date

APPENDIX A
BLOOD AND BLOOD PRODUCT SERVICES
Community Hospital East

I. AGREEMENT

A. Except as otherwise provided in this Agreement, the Blood Center shall provide to the Client one or more of the blood and blood product services as described on Exhibit A-1 and the Client shall pay the Blood Center the service fees set forth in Exhibit A-1.

B. Transportation:

1. Unless otherwise agreed, the Blood Center shall provide to the Client routine delivery service for blood and blood product services.
2. The Blood Center shall provide to the Client emergency delivery service for the emergency delivery service fee set forth in Appendix X.
3. The Blood Center shall provide and retain ownership of transportation containers and equipment for use in providing the routine delivery service for blood and blood product services.

II. RECALLS/MARKET WITHDRAWALS

A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Consignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Indiana Blood Center
EXHIBIT A-1
BLOOD PRODUCTS/SERVICES
Community Hospital East

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
LRBC/RBC	P9016	1100, 1105, 2205	275.00
LRBC/RBC - Autologous (Administrative fee is additional)		1100, 1105, 2205	275.00
LRBC/RBC - Irradiated	P9040	1103, 1108	350.00
LRBC/RBC - Deglycerolized	P9054	1400, 1405, 2405	350.00
LRBC/RBC - Frozen	P9057	1300, 1310, 2310	350.00
LRBC/RBC - Washed	P9054	1200, 1201, 2210	350.00
Whole Blood	P9010	1000	400.00
Cryoprecipitate	P9012	3000	75.00
Cryoprecipitate - Pooled	P9012 X 5	3010	450.00
Apheresis Platelets, Leuko Reduced, Bacterial Detected	P9035	2100	650.00
Apheresis Platelets-Irradiated, Leuko reduced, Bacterial Detected	P9037	2103	705.00
– HLA Typed Surcharge		9105	150.00
AFFP (400 ml)	P9017 X 2	2001	131.00
AFFP Pediatric pack (per individual pack)		2003	32.00
Frozen Plasma < 24 hours (250 ml)	P9017	2000, 3050, 3070	54.00
Frozen Plasma - Cryo Poor	P9044	3055	70.00
CMV Neg charge	86644	5061	18.00
Irradiation fee for one to five platelet concentrates	B9006	9106	55.00
Neonatal Pack Surcharge			
– Neo 3		9120	30.00
– Neo 4		9121	35.00
– Neo 6		N/A	40.00
– Neo 8		9123	50.00
Imported Product Surcharge Fees:			
– Import fee (one fee per imported unit, per patient)		9159, 9160, 9170	150.00
– Excess fees above the Blood Center charges will be passed onto the hospital			*

Legend: LRBC – Leukoreduced Red Blood Cell
RBC – Red Blood Cell
AFFP – Apheresis Fresh Frozen Plasma
FFP – Fresh Frozen Plasma

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
Source Leukocyte	85009	3106	40.00
Segments for Crossmatching (each group of 20)		9442	20.00
Packing Whole Blood (up to 4 units)		9168	30.00
Washing Platelet (per unit) (additional fee for one FFB used in processing)	B9064	9165	75.00
One Liter Wash (per unit)	B9064	N/A	75.00
Glycerolizing & Freezing	B4001	9158	75.00
Deglycerolizing	B4001	9163	85.00
Apheresis Special Draws		N/A	*
Donor / Patient Services			
Autologous Donation Fee (per unit)	86890	9102	300.00
Autologous Apheresis Donation Fee (per donation)	86890	9102	300.00
Directed Donation Fee (per unit)		9103	300.00
Additional Handling Fees - after hours, without appointment (per unit)		N/A	200.00
Annual Storage Fee for Autologous Frozen Cells		N/A	150.00
Off-site Draw Fee (per unit)		N/A	*
After Hours Charge - Apheresis		9150	350.00
Blood Derivatives			
Rho Gam (per package)	J27790		**
V-Zig Immune Globulin *(comes in volume 125 & 625)*			**
Factor 8	J7190, J7191, J7192		**
Non-Blood Products			
Platelet Leukocyte Removal Filters			
– PLX8C	PLX8C		***
– PLX12C	PLX12C		***
Red Cell Leukocyte Removal Filters			
– RCXL1C	RCXL1C		***

Regular hours are Monday – Friday, 5:30a.m.–6:30p.m; Saturday, 6:30a.m –12:00noon (excluding holidays)
Services outside of these hours may incur additional charges

* Price based on order
** Fees are subject to change
*** Price based on the manufacturer's charge

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
Complete Donor Profile and NAT HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH, HIV 1/ HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5502	89.00
Complete Donor Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (ABS) Antibody Screen, (STS) Syphilis, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86900, 86901, 86850	5503	68.50
BMR Panel HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV, ABORH	87340, 86704, 86703, 86687, 86688, 86803, 86592	5151	67.50
Infectious Disease Profile Only HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, HIV 1/HCV NAT *	87340, 86704, 86703, 86687, 86688, 86803, 86592	5120	74.25
Tissue Bank Profile HBSAG, HCV, HIV 1/2, HBC, HTLV-I/II, (STS) Syphilis, CMV	87340, 86704, 86703, 86687, 86688, 86803, 86592, 86644	5091	64.00
Fertility Donor Profile HBSAG, HCV, HIV 1/2, HBC, (STS) Syphilis	87340, 86704, 86703, 86803, 86592	5552	58.25
ABO Group & Rh Type (donor)	86900, 86901	5030	10.50
ABO Group & Rh Type (cord)	86900, 86901	5031	12.50
Antibody Screen	86850	5200	10.50
Antibody to CMV	N/A	5060	5.50
Antibody to HB Core (EIA)	86704	5040	17.00
Antibody to HCV (EIA)	86803	5105	18.00
Antibody to HIV 1/2 (EIA)	86703	5110	17.00
Antibody to HTLV-I/II (EIA)	86687, 86688	5082	17.00
Cholesterol	82465	5220	5.50
HCV/HIV1 NAT (pool)	donor only	5007	19.25
HCV/HIV1 NAT (individual)	donor only	5011	31.00
WNV NAT (pool)	donor only	5008	11.00
WNV NAT (individual)	donor only	5012	19.25
Hepatitis B Surface Antigen (EIA)	87340	5010	17.00
Syphilis (STS)	86592	5086	5.25
Antibody to HBs (EIA)	86706	5020	15.75

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
Syphilis Confirmatory	86781	5090	48.75
RPR Titer		5088	11.00
RPR Titer w/FTA if ind		5089	44.00
HBsAg Confirmatory Neutralization	86382	5005	157.50
HCV Immunoblot Assay	86804	5095	152.25
HIV1 Western Blot and HIV2 Antibody Confirmation	86689	5125/5127	126.00
HIV2 Western Blot	86689	5124	156.50
HTLV Antibody by WB	86689	5096	111.50
HTLV I/II Antibody w/WB if ind	86687	5129	21.25
HIV-1 Whole Viral Lysate	Donor only	5126	124.50
CMV IgG/IgM	86644/86645	5161	54.50
GC/Chlamydia	87490, 87491, 87590, 87591	5128	64.50
Chagas	87449	5021	20.00
Chagas RIPA	86753	5121	500.00
Leishmania IFA	86717	5101	131.25
Complete Blood Count			7.50

The laboratory can be reached at 317-916-5190, Monday-Saturday. If no answer, call 317-916-5279 to have the staff paged.
* Panel prices are for pooled pricing. Individual WNV NAT is an additional $7.60

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
ABO & Rh	86900, 86901	4000 RC	35.70
Allogeneic Adsorption	86971, 86978	4210	204.00
Antibody Identification	86870	4020 RC	97.00
Autoadsorption	86971, 86978	4220	153.00
Chloroquine/EGA Treatment of RBC's	86860	4270	142.75
Compatability Screening	86922	4070	40.75
Direct Antiglobulin Test	86880	4060	46.00
Donor Antigen Test, confirmed per antigen			
– CEceK	86903	4041 UPH	49.00
– AHG	86903	4042 UPH	72.50
– Direct	86903	4043 UPH	79.50
– Rare Low Frequency	86903	4044 UPH	79.50
– Rare High Frequency	86903	4045 UPH	118.25
Saline Replacement	86977	4320	20.50
DTT Treatment of RBC's	86970	4271	71.50
Eluate	86860	4290	132.50
Enzyme Treatment of Panel	86971	4250	66.25
Hemoglobin Screening	85660	4082 UPH	46.00
Microhematocrit/Hypotonic Cell Separation	86972	4280	86.75
Neutralization (HPC/Plasma/ Lewis/ P)	86977	4260	102.00
Patient Antigen Test			
– Rh Phenotye	86906	4031 RC	128.50
– CEceK (individual antigen)	86905	4032 RC	49.00
– AHG	86905	4033 RC	72.50
– Direct	86905	4034 RC	79.50
– Rare Low Frequency	86905	4035 RC	79.50
– Rare High Frequency	86905	4036 RC	118.25
Pre-warm	86940	4230	51.00
Titration	86886	4240	66.25
Triple Adsorbing Cells	86971	4084	61.25
RBC Molecular typing (patient)	83891, 83900, 83901x22, 83892x2, 83912, 83914x22	4115 P	510.00
RBC Molecular typing (donor)		4115 U	153.00
ARDP Fee (per unit)	86999	4105	204.00
Export Fee for Rare units (per unit)	86999	9171	127.50
Import Fee for Rare units (per unit)	86999	9170	127.50
Coordination/Consultation Fee	86999	4120	81.50
STAT Fee, For immediate provision of services Mon -Thur evenings and overnight and Fri evening	86999	4130	255.00
STAT Fee, For immediate provision of services during holidays, Fri overnight, Sat and Sun	86999	4130 N	510.00

The Blood Center Reference Laboratory is available on-site or on-call 24/7 by calling

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
ROUTINE ITEMIZED TESTING		
1. HLA Typing (ABC)	83891, 83896x224, 83898x3, 83912	400.00
2. HLA Typing (ABCDRDQ)	83891, 83896x224, 83898x3, 83912	500.00
3. ABO	86900	15.00
4. Autocrossmatch T-Cell Flow	86805 X 6	212.50
5. Autocrossmatch B-Cell Flow	86805 X 6	212.50
6. Crossmatch (Donor T-Cell) Flow	86805X6	212.50
7. Crossmatch (Donor B-Cell) Flow	86805 X 6	212.50
8. Flow Antibody Screen Class I PRA	88184, 88185, 88187	158.00
9. Flow Antibody Screen Class II PRA	88184, 88185, 88187	158.00
10. Antibody Identification Class I	88184, 88185, 88187	350.00
11. Antibody Identification Class II	88184, 88185, 88187	325.00
12. Donor Specific Antibody DSA Class I	88184, 88185, 88187	350.00
13. Donor Specific Antibody DSA Class II	88184, 88185, 88187	325.00
14. SPRCA Crossmatch (HLA or Single Donor) Platelet	86806	165.00
15. Platelet Antibody Screen	86022	200.00

ROUTINE PANELS for Ease of Ordering (See itemized listing for tests included in panel)	**TEST NUMBER** (Routine itemized Testing List)
Platelet Support Services	
Hematology Profile	1, 3, 10, 15
HLA Class I PRA and Antibody Identification Class I (Flow)	8, 15
SPRCA Crossmatch (HLA or Single donor) Platelet	14
Cardiac/Renal Services	
Transplant Candidate Profile	2, 3, 4, 5, 8, 9, 10, 11
Cadaveric Transplant Donor	3
Living (renal)Transplant Donor Profile	2, 3
Cardiac/Renal Transplant Recipient (day of transplant)	6, 7, 8, 9, 10, 11
Bone Marrow Transplant	
Bone Marrow Transplant Profile	2, 3, 8, 9
Bone Marrow Donor	2
Neonatal Alloimmune Thrombocytopenia (NATP) Panel	10, 14, 15
TRALI Investigation	No Charge for the Blood Center Units

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
Other Services		
Platelet Antigen Typing		
Full Platelet Antigen Typing (HPA-1,2,3,4,5,6,15)	83896 x 2,83912	360.00
PLA1	83896 x 2,83912	175.00
Disease Association Profile		
HLATyping (AB/DR/DQ) per antigen	83891,83896x224,83898x3,83912	200.00
Parathyroid Tissue Cryopreservation	60500	850.00
Parathyroid Freezing Solution Sterility Check	87070, 87102	150.00
Parathyroid Tissue Release/Transportation Charges		varies with shipping
Parentage Testing		
Trio (Domestic)		490.00
Trio (International)		550.00
Single Parent Testing (Domestic)		550.00
Single Parent Testing (International)		585.00
Siblingship Testing (each person tested)		300.00
Each additional client		200.00
Specimen Collection Fee (out of state)		37.00

Regular hours are Monday – Friday, 8:00a.m.–4:30p.m. (excluding holidays)
Services outside of these hours will incur an additional STAT charge of $250.00 per order

RECALLS/MARKET WITHDRAWALS

A. In the event that blood products are recalled or withdrawn due to unsuitability, the parties shall comply with the responsibilities regarding notification and other actions to be taken set forth in the Cosignee/Recipient Notification of Recalls/Market Withdrawals, attached hereto as Exhibit A-2, and incorporated herein.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial [signature] Date 8-19-13

EXHIBIT A-2
CONSIGNEE/RECIPIENT NOTIFICATION
OF RECALLS/MARKET WITHDRAWALS

The Blood Center shall notify the Client of recalls and market withdrawals of blood products as soon as possible after discovery of a reactive screening test or other reason for product unsuitability.

I. The Blood Center shall notify the Client as soon as possible, and no later than 72 hours of test completion of any potentially infectious disease marker or other reason for product unsuitability for blood products the Client has received from the Blood Center. For products intended for transfusion, the scope of review will include all of the donor's units collected within the past five (5) years. For products intended for further manufacture into injectable products, the scope of review will include all of the donor's units collected within the past six (6) months.

A. Current positive tests for HIV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HIV ABY repeat reactive lookback extends back 5 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HIV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

B. Current positive tests for HCV for donors with prior donations:
- Consignee will be contacted within three (3) calendar days (typically by phone) to determine the disposition of in-date, and thus potentially available, components.
  - HCV ABY repeat reactive lookback extends back 10 years or 1 year prior to the last negative test of record, whichever time is shorter.
  - HCV NAT reactive lookback extends back 12 months from the date of the current reactive test of record.
- Available components are to be returned to IBC for credit.
- Per applicable guidance, consignee will be contacted as soon as possible, and within 45 days, once additional testing is complete and confirms infectious disease markers. Recipient Data Sheets will be utilized to document cases needing Recipient Tracing.
  - Consignees should perform Recipient Tracing per applicable guidance and return Recipient Data Sheets to IBC, Clinical Services within guidance specified time frames (e.g. 45 days from notification receipt).

C. Other lookbacks, recalls, or reasons for Post Donation Information:
   - Notifications and recalls will be made similarly as above and in accordance with applicable guidance; however, for recalled products that are no longer potentially available (post-expiration date), written notification using IBC forms (e.g. Post Donation Information Consignee Notification form, Recipient Data Sheet, etc.) will be sent to the transfusion service. If requested, such forms should be returned as soon as possible, and within 15 days to allow for meeting FDA BPDR reporting timeframes.

II. The Client shall have a clearly defined and written policy that ensures recall notifications from IBC are appropriately received and managed per applicable guidance, and that recalled products are not inadvertently distributed for transfusion. The policy shall include identification of the person responsible for performing this activity, how the units are identified as "in quarantine", and how the units are physically separated from the regular blood inventory. The Client shall, upon request, provide the Blood Center with a copy of the written policy.

References:

- 21 CFR §§ 610.46-610.48

- *Guidance for Industry: Nucleic Acid Testing (NAT) for Human Immunodeficiency Virus Type 1 (HIV-1) and Hepatitis C Virus (HCV): Testing Product Disposition, and Donor Deferral and Reentry.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, May 2010.

- *Guidance for Industry: "Lookback" for Hepatitis C Virus (HCV): Product Quarantine, Consignee Notification, Further Testing, Product Disposition, and Notification of Transfusion Recipients Based on Donor Test Results Indicating Infection with HCV.* U.S. Department of Health and Human Services, Food and Drug Administration, Center for Biologics Evaluation and Research, December 2010.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial [signature] Date 8-19-13

APPENDIX B
TESTING SERVICES

I. AGREEMENT

A. The Blood Center shall provide to the Client one or more of the Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services set forth in Exhibit A, attached hereto and incorporated herein, upon submission of the appropriate testing request form by the Client and the Client shall pay the Blood Center the service fees set forth in Exhibit A,

II. TESTING PROTOCOL

A. Testing Request Process

1. The Client shall comply with the applicable testing request processes described in the Customer Resource Manual when the Client requests Testing Laboratory Services, Immunohematology Reference Laboratory Services, or Histocompatibility Laboratory Services.

B. Sample Requirements

1. The Client shall collect, label, store, pack, transport and ship all blood samples in accordance with applicable federal, state and local laws and in accordance with the Customer Resource Manual.
2. The Blood Center shall provide packing materials to the Client upon request.

C. Sample Transport

1. The Client shall transport all blood samples in accordance with the Customer Resource Manual.
2. The Client shall pack samples in accordance with federal, state or local regulations and shipping container manufacturers' specifications and requirements for clinical/diagnostic specimens.
3. The Client shall transport samples at refrigerated temperature to the testing laboratory located at Central Indiana Regional Blood Center, Inc., d/b/a Indiana Blood Center, 3450 North Meridian Street, Indianapolis, Indiana 46208.
4. The Client shall pay for all costs for transporting and shipping to the Blood Center or Third Party Laboratories and reimburse the Blood Center for any freight costs incurred by the Blood Center.

D. Sample Integrity

1. The parties agree that that the integrity of the specimen received by the Blood Center dictates the integrity of the results obtained. The parties agree that the Client must properly collect, store, identify, pack, and ship samples to ensure accurate and efficient processing of the samples.

2. The parties agree that the Blood Center shall not be responsible for any delay in processing under the following circumstances:
    a) The sample and supporting documentation accompanying the shipment is incomplete or in a condition not reasonably satisfactory to the Blood Center (or its Third Party Laboratory) in accordance with the guidelines specified in the Customer Resource Manual;
    b) The sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
    c) The specimen contains incorrect information for sample shipment reconciliation;
    d) Any aspect of sample identification is incorrect or illegible;
    e) The specimen is not the appropriate quantity, type, or age; or
    f) The Blood Center determines, in its sole judgment, that the specimen has not been properly stored.

E. Sample Receipt and Turn-Around Time

1. Upon receipt of a sample from the Client, the Blood Center shall:
    a) Notify the Client of any damaged samples or any inadequate documentation relating thereto promptly after the arrival of a shipment at the Blood Center or its Third Party Laboratory; and
    b) Handle the samples with all due care for as long as the samples are within the Blood Center's control.
2. Upon receipt of a sample from the Client, the Blood Center may, in its sole discretion:
    a) Refuse to perform services hereunder in any instance in which the Blood Center deems that the samples or related documentation are not in reasonably satisfactory condition; or
    b) Refuse to perform services hereunder in any instance in which the Blood Center deems that the sample does not contain an appropriate Barcode label as required by the Customer Resource Manual;
3. The Blood Center shall complete testing, review and reconciliation of records and transmit test results to the Client in accordance with the testing schedules set forth in the Customer Resource Manual for Testing Laboratory Services, Immunohematology Reference Laboratory Services, and Histocompatibility Laboratory Services.
4. The Blood Center shall immediately convey results from any specimen that registers a critical value to the appropriate Client personnel by telephone, facsimile or other electronic means.
5. The Blood Center shall provide the Client with the following technical information for all tests:
    a) Normal values;
    b) Technical method of analysis; and
    c) Specimen requirements, including special handling instructions.
6. The Blood Center shall notify the Client a minimum of 30 days in advance of significant changes in the test protocols, reagents sample volumes or sample types set forth in the Customer Resource Manual.
7. The Blood Center shall not provide STAT testing unless the parties agree in writing upon the terms, conditions, and fees for STAT testing.

F. Test Performance and Procedures:

1. The Blood Center shall perform and cause its Third Party Laboratories to perform the blood testing services and interpret blood test results in accordance with applicable laws, regulations, manufacturer's package insert instructions (except where otherwise approved by the United States Food and Drug Administration (FDA), and use testing procedures at least as stringent as those recommended by the American Association of Blood Banks (collectively the Regulations).
2. The Blood Center shall perform blood testing services with licensed screening and confirmatory tests or, in the absence of licensed confirmatory tests, by a confirmatory test recognized as appropriate by standard of care and standard industry practices.
3. The Blood Center shall use FDA licensed reagents whenever available.
4. The Blood Center shall provide to the Client copies of the package inserts of each of the assays that the Blood Center and any Third Party Laboratories will perform.
5. The Blood Center shall implement any new immunohematology and viral marker tests approved for use in blood banking/screening by the FDA or applicable standards upon written agreement by the parties of the service fees for such new immunohematology and viral marker tests.
6. The Blood Center and the Client shall comply with applicable state reporting requirements with regard to infectious disease markers.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial [signature] Date 8-19-13

APPENDIX X
SERVICES AGREEMENT – COMMITTED VOLUMES
COMMUNITY HOSPITAL EAST

I. PURCHASE COMMITMENT

A. Client and the Blood Center shall agree upon Annual Unit Quantity or percent of amount to be purchased under this agreement, which shall be as follows:

Product Unit	Price per Unit ($)	Annual Unit Quantity or % of Annual Purchased Amount
LRC	215.00	3,415
APLT	500.00	250
FP24	50.00	1,030
CRYO	43.00	16
POOLED CRYO	300.00	16

B. Pricing for the Committed Volume shall be determined on an annual basis, provided, however, the Blood Center may adjust the price if, in any 3-month calendar quarter (i.e., January-March, April-June, etc.), the quarterly purchases by Client are not within five percent (5%) of the quarterly volume as set forth below for the quarter just completed, in which case, pricing shall default to Blood Center list pricing set forth on Exhibit A-1.

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Total
LRC	866	856	837	856	3,415
APLT	63	63	61	63	250
FP24	261	258	253	258	1,030
CRYO	4	4	4	4	16
POOLED CRYO	4	4	4	4	16

II. DELIVERY AND TRANSPORTATION

A. Routine delivery. The Blood Center shall provide scheduled delivery one (1) time per weekday (Mon-Fri) and once Saturday morning at no charge.

B. Additional delivery. Deliveries requested by the Client beyond the routine delivery will be made the most cost-effective way, one way or round trip, depending on the customer need and ability to schedule the delivery for an additional fee of:

One-way fee	$15.00
Round-trip fee	$30.00

C. Emergency Delivery. Emergency delivery fee will be added to the delivery for those orders which require immediate delivery at the then-current emergency rates charged by third-party delivery services plus a reasonable administrative fee.

D. Transfers. Products transferred from the Client will be credited to Client's account at the service fee in effect at the time the product was shipped to the Client. Products transferred to the Client will be invoiced at the Client's current service fee in effect.

III. RETURNS

Red Cells received with 10 days or more remaining before expiration will be given full credit for the Leukoreduced Red Cell product, excluding any additional special services provided for that unit, in the amount of the service fee in effect at the time the product was shipped to the Client. Apheresis Platelets received with 24 hours or more remaining before expiration and resold, will be given full credit in the amount of the service fee paid in effect at the time the products were shipped to the Client in the month following the calendar quarter end. Special order Apheresis Platelets including Irradiated, HLA matched and cross-matched are not eligible for credit.

IV. STANDING ORDERS

Client may establish a written standing order for blood and blood product services. Standing orders submitted to the Blood Center by any client will be filled ahead of additional orders submitted by the Client. Changes in Client's standing order require seven (7) days written notification, provided, however, such changes may only be made one time per calendar month. Client is to submit a standing order to Blood Center within seven (7) days of contract execution.

To assist both client and Blood Center with utilization review, installation of the AIM software is to be included as part of this process.

Blood Center:
Initial BBB Date 6-27-13

Client:
Initial _____ Date 8-19-13

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE **NPP#: I-14B1**
Approved For: [X] **CHE** [X] **CHN** [X] **CHS** [X] **CHVH** **Page 1 of 12**
CANCELS: 5/21/13emergent **EFFECTIVE: 8/8/13**

TITLE: Blood Component Administration

Performed by:
1. Obtain blood components from Blood Bank: RN, LPN, MHC, PSP, PST, AP, SE, EMT-P (competency verified). Nursing may request Security to obtain blood component from Blood Bank.
2. Start Infusion and administer blood products: RN, LPN, NP, CNS

Purpose: To provide guidelines for administering blood components.

Policy Statements:
1. A patient **must** be identified prior to the administration of any blood product according to **CLN 3017, Identification of Patient, Use of Two Patient Identifiers**. If the patient is able to communicate, ask the patient to state their name and birthdate. Additionally, verification of patient identification will occur by comparison of patient name, birthdate and medical record number on the blood product slip and the EMR to the patient name, birthdate, and medical record number on the patient's armband. If the patient is unable to communicate, nursing will compare the EMR, patient's armband, and blood product information and verify that all are accurate. All information will be an identical match to patient EMR, armband and blood product. If any information is not correct the blood product must be returned immediately to the blood bank.
2. A physician order is required to administer blood components. Blood Consent/Refusal form must be completed for all blood component transfusions, which includes: Red Blood Cells, Plasma, Cryoprecipitate and Platelets. The form should be signed before obtaining the Type and Crossmatch (T&C) or Type and Screen (T&S) blood sample, but must be signed before the blood component is administered. **(Exception: Physician order to administer blood without the patient's consent in an emergency situation. If blood is administered in an emergency without consent, the reason must be documented in the patient's medical record.)** The consent remains in effect during the hospitalization and a new consent is required for each new inpatient admission. A new consent is required when a patient is admitted to or from Behavioral Health or Rehabilitation Hospital or from an outpatient to an inpatient status.
3. IgG or Rh Immune Globulin are not blood components and do not require signed consents before administration.
4. A red Blood Bank Armband (Blood Recipient ID Band) will be placed on all patients who have a T&S/T&C drawn in an outpatient area/Emergency Department, or on all patients who do not have a Medical Record number. The armband must remain on the patient until midnight of the third day after the T&C/T&S specimen was drawn. If present, this armband must be used as a method of identification. If removed during this period, a new T&S/T&C must be ordered and a specimen drawn.
5. Do not obtain blood products from the Blood Bank until a working patient IV is established. (Exception: Emergency Situations.) The physician's order or the RN's judgment regarding the condition of the patient will be used to determine whether or not to interrupt an already existing IV infusion or to start a second IV site to administer the transfusion. If infusing parenteral nutrition, ($D_{10}W$ concentration or greater and/or lipids), or a continuous PCA narcotic, a second IV site must be started. If unable to obtain a second IV site receive orders from physician for possible interruption of other therapies that cannot be given during blood component infusion.
6. If the patient has an arteriovenous (AV) graft or fistula, blood may not be infused through the graft or fistula unless it is during dialysis.
7. A computer generated requisition to obtain blood label with the patient name (first and last), medical record number, and DOB must be presented when picking blood components up from the Blood Bank. Exception: A handwritten label with the patient's first and last name, Medical Record

Number, and DOB may be used if the patient's condition warrants emergency blood administration and a computer label is not readily available. The person picking up the blood component from the Blood Bank (known as the transporter) must be aware which blood component is to be obtained if the patient has multiple blood components ordered. Blood bank personnel are to be informed by transporter which product component is needed. NOTE: If patient has a red armband, the sticker from the red armband must accompany the label with patient's name, DOB and medical record number in order to pick up the blood.

8. Uncrossmatched red blood cells will be given in an emergency situation when a T&C/T&S specimen has not yet been obtained, but T&C must be obtained as soon as possible and sent to Blood Bank. See NPP#I-14,B-2, Blood, Uncrossmatched for additional information.
9. Blood tubing must not hang for greater than four hours. If more than one blood component is infused, the blood tubing must be changed if the infusions are not completed within the four hour time period. No more than four red cell products can be infused through the same blood tubing.
10. **All blood components must be started and be completely infused within four hours from the time the units leave the blood bank.**
11. **If it is necessary to infuse longer than this, prior arrangements must be made with Blood Bank.** Blood Bank will arrange smaller volumes ("aloquets")to infuse if necessary; for example, Pediatric patient or patients with CHF.
12. If the blood component cannot be started upon arrival to the unit it must be returned to Blood Bank as soon as possible to avoid wasting it..
13. Multiple blood components on a single patient can be released to a nursing unit if the patient's condition warrants. Under no circumstances is blood to be stored in a refrigerator on the nursing units. **Coolers will be provided to nursing by the Blood Bank for the storage of multiple units in surgery, critical care areas, ED or transfusions taking place at areas remote to the blood bank. These coolers are for the use of red cells and plasma products. Platelets and cryoprecipitate are stored at room temperature. The coolers are labeled with information stating when the ice in the cooler must be replaced or returned to the blood bank.**
14. For the pediatric patients less than 100 pounds, the physician must order the amount and rate of blood administration. If this is not specifically ordered, the physician must be contacted.
15. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion:
    a. By checking the specific physician order for accuracy of blood component to be administered before hanging the component.
    b. By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the start time of the transfusion and the second set of vital signs between the first 10 and 20 minutes of the infusion.
    c. By obtaining patient temperature a minimum of every 30 minutes during the transfusion when clinically indicated for signs and symptoms of a possible reaction.
    d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion.
    NOTE: If a transfusion takes less than 15 minutes to complete, the 15 minute assessment and the completion assessment may be completed and documented at the same time, the vital signs would be completed in the post transfusion section and the pre transfusion section for the next unit.
16. During the transfusion of all blood components products or upon its completion, if the patient experiences a 2^{0}F increase or more (one degree Celsius) in temperature, or any other sign/symptom of a transfusion reaction, the transfusion is to be stopped. Call the Blood Bank immediately, receive instructions for transfusion reaction work-up and notify physician. The Blood Bank will inform the nurse of the necessary items for a Transfusion Reaction Work-Up. (These include: post transfusion blood bank specimen correctly labeled, yellow copy of the transfusion record form with reaction information completely filled out, all tubing, filters, fluids and blood components used in the transfusion, and the Transfusion Reaction work up order

requisition.) Orders received from the physician and rationale for interventions must be documented.

17. **In the event that the patient dies while receiving a transfusion,** perform the following: **document on the transfusion record form that patient died, contact blood bank, send all paper work and tubing to the blood bank, and if possible obtain a post transfusion specimen.**
18. No medication is to be added to or administered with blood components. Use only normal saline (0.9% saline) with blood components.
19. All crossmatched blood and T&C/T&S orders will be automatically released at midnight of the 3rd day from when the specimen is collected. Should the patient require blood after this time period, a new order and crossmatched specimen must be obtained. EXCEPTIONS include pre-op T&C and Pre-op T&S which may be extended for 30 days with pre-op questionnaire.
20. A patient refusing to receive blood for religious or other reasons must sign the Blood Consent/Refusal form section. See Corporate Policy CLN:2062, "Blood Transfusions, Refusal Considerations".
21. Patients requiring transportation while receiving a transfusion must have an RN, Perfusionist or physician in attendance. Hand off to the unit of destination must be to an RN, Perfusionist or physician.

General Information:

1. Potential signs and symptoms of a transfusion reaction include: chest pain, back pain, itching, rash, hives, shortness of breath, feeling anxious, increase in temperature greater than or equal to 2 degrees Fahrenheit or 1 degree Celsius from pre-transfusion baseline vital signs or anything out of the ordinary.
2. Patient identification consists of inspection of the identification armband to verify that the name, date of birth and medical record number are the same as on the Transfusion Record Form and the blood component unit label. If a red Blood Bank Armband (Blood Recipient ID Band) present, this armband must be used as a method of identification.
3. Unit(s) identification consists of verification from the blood component unit label, including:
   a. Patient's Name
   b. Medical Record Number or identification number on red blood bank armband(Blood Recipient Identification Band)
   c. Date of Birth (DOB)
   d. Donor number
   e. Blood Type of unit
   f. Blood type of patient
   g. Unit Expiration
   h. Other specifics, for example, irradiated, CMV.
4. T&C/T&S at CHVH, CHN, CHE, or CHS and processed by Mid America Clinical Laboratories is valid for use at all sites listed above. Any patient transferring from any other location needs need a new T&C and T&S drawn.
5. A physician, NP, CNS or Perfusionist may start infusion and administer blood products.
6. It is recommended that intravenous catheter sizes for use in transfusing cellular products, (Red cells and platelets), range from 14 to 22 gauges.
7. All Red Blood Cells received from Indiana Blood Center are Leukoreduced.

Equipment:

1. IV Pole
2. Blood Administration set
   a. Double Y- type blood tubing (Whole Blood, Packed Cells, and FFP, Platelets, Leukocytes, and Cryoprecipitate)

b. 30ml syringe with filter needle (Factor VIII/Factor IX)
3. Blood warmer (optional) is ordered by physician. (Instruction sheet on machine.)
4. Infusion pump if blood component is to be infused through a central line. An infusion pump is optional if a blood component is infused peripherally.
5. 250 ml Normal Saline (0.9% saline)

A. Obtaining T&C or T&S (Type and Cross/ Type and Screen):

1. If T&C or T&S is needed, identify the patient using the two patient identifiers as described in CLN 3017, Identification of Patient, Using two patient identifiers.
2. Obtain specimen by drawing blood in Blood Bank designated vacutainer tube.
3. On the vacutainer pre-affixed label and print **in indelible ink** the following information:
   a. Patient's full name
   b. Patient Date of Birth
   c. Medical Record number
   d. Date, time and phlebotomist's initials
4. Complete collection information on the lab requisition to include:
   a. Date/time of collection
   b. Phlebotomist's initials
   c. Notation that hospital or red blood bank arm band is present when specimen was drawn.
   d. One additional patient identification item listed below
      1.) Patient said name was:_____
      2.) DOB
      3.) Staff identification of patient
5. Place a red blood bank armband (Blood recipient Identification Band) on patients who have had T&C/T&S drawn in outpatient areas or before a Medical Record number is available. Affix the patient ID portion of this armband on to the tube of blood in the presence of the patient.
6. Place specimen, strip of armband numbers if using Identification Band and requisition in plastic bag and deliver to Blood Bank. Blood Bank refuses specimen if:
   a. There is incomplete labeling of specimen including misspelling of any portion of the name, missing medical record numbers including zeros and omission of date/time of collection and phlebotomist's initials.
   b. There is inaccurate labeling of specimen which includes using printed labels for T&C and T&S.
   c. Specimen labeling is not in agreement with requisition.

B.Obtaining Blood Component(s) from the Blood Bank

1. The transporter hands the pick-up slip to the Blood Bank associate at Blood Bank If the patient has a red armband, the sticker from the red armband accompanies the label with patient's name, DOB, and medical record number in order to pick up the blood.
2. The Blood Bank associate retrieves the blood component(s) and dispenses in the laboratory computer.
3. The transporter then reads to the Blood Bank associate the following from the Transfusion Record Form:
   a. Patient Name
   b. Medical Record Number
   c. Date of Birth
   d. Patient ABO/Rh
   e. Unit ABO/Rh
   f. Unit number and correlating red armband number if appropriate
   g. Component
   h. Crossmatch results

i. Unit expiration date and time
j. Comment

4. The transporter then signs the Transfusion Record Form (s) in the area **TRANSPORTED BY** along with the date and time, and the department where the transfusion will take place.
5. The transporter hands the Transfusion Record Form (s) back to the Blood Bank associate to sign in the area marked Technician Issuer
6. The Blood Bank associate removes the pink copy from the Transfusion Record Form (s) and places the Transfusion Record Form, Blood Bag label and blood component in a bag (either paper or plastic) or cooler for transportation to the nursing unit.
7. The Blood Bank associate dates and writes the 4 hour blood product outdate time on the Blood Bag Label sheet and includes this in the bag or cooler for transportation to the nursing unit.
8. Pneumatic Tubing of Blood and Blood Products for NICU and CHVH (weekends only for CHVH):Complete the Blood Pneumatic Tube Transport form (see addendum # 3).
   a. Perform 2 patient Identifiers with physician order before sending form to Blood Bank
   b. If patient has a blood bank band include the number in the space provided on form
   c. Handwrite the patient's full name and birthdate, Medical Number, and Room number
   d. Fill in number of Product Requested:_____
   e. Quanity:_____ Tube Station:_____
   f. Phone:_____Initials:_____
   g. Follow the instructions to "Send request form via pneumatic tube"
2. Blood Bank :
   a. Completes the "Date/Time Product Sent" section of the Blood Pneumatic Tube Transport form and they will retain the bottom (yellow) copy
   b. Notifies the Clinical area that the blood product is being sent.
   c. Places product, Blood bag label dated with the 4 hour blood product outdate time and top copy of transport form in sealed Ziploc bag(s). Place
   d. Ziploc bag into a pneumatic tube.
   e. Blood bank tech calls receiving area if "Blood Pneumatic Tube Transport" form is not returned to the Blood Bank within 15 minutes.
3. Clinical area removes unit from the pneumatic tube system and
   a. compares the information on Unit Compatibility label, Transfusion Record Form and Blood Product Request Form.
   b. Complete the "Receipt" section of the Blood Pneumatic Tube Transport form
   c. Returns the form and the refrigerated gel pack (if applicable), via the tube system to the blood bank.
   d. Two members of the transfusing staff verifies donor unit information per Blood Administration policy, with the transfusion tag and patient wristband information at the patient's bedside.
   e. If there are any discrepancies, the Neonatal Intensive Care Unit (NICU) personnel will **WALK** the unit back to the Blood Bank for resolution. For discrepancies at The Indiana Heart Hospital (CHVH) the staff call the Blood Bank for further instructions.

C. Transfusion

1. Complete bedside verification process using the Transfusion Record Form. Utilizing two 2 staff members, one of which is a licensed professional (RN, LPN, Physician/NP, Perfusionist).Compare -the specific physician order for accuracy of blood component to be administered before hanging the component. Scans the blood bag for the unit number and the product code number.
2. Compare the patient's name, DOB, and medical record number on the identification armband with the patient's name, DOB and medical record number, and if applicable the red armband number on the Transfusion Record Form and the blood component unit label.

3. Compare the unit number, ABO group, and Rh on the blood component unit label with the unit number ABO group, and Rh on the Transfusion Record Form. Contact Blood Bank immediately for any discrepancies.
4. Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion. If patient's temperature is 101^{0}F or above, notify the physician prior to starting the blood component and receive orders.
5. Attach blood component to prepared IV tubing.
   Infuse at:

Component	1st 15 minutes	After 15 minutes	Pediatric
Red Blood Cells	75 ml/hour	150 ml/hr	2-5mL/kg/hr
Plasma	NA	200-300ml/hr	60-120 mL/hr
Platelets	30ml/hr	200-300mL/hr	60-120mL/hr
Cryoprecipitated AHF	As Rapidly as Tolerated		As Rapidly as tolerated

6. The RN observes the patient closely, assessing and monitoring the patient for the first 15 minutes after the transfusion is started to observe for potential signs and symptoms of a transfusion reaction.
7. Between the first 10 and 20 minutes of the infusion, obtain vital signs including temperature, pulse, respiratory rate, and blood pressure and document the complete vital signs on the Transfusion Record Form. Observe the patient for shaking, chills, pain, nausea, itching or other symptoms and document. If the patient's condition is satisfactory, the rate can be increased to that listed in the table above.
8. Continue to monitor and assess the patient intermittently throughout the transfusion.
9. If a unit of blood has been infusing for more than 4 hours, discard remaining blood in red biohazard containers in dirty utility area and completely change all IV tubing that was used for transfusion.

D. Post Transfusion:
1. After transfusion is complete, flush blood tubing with normal saline, then discard all blood tubing, bag and supplies from transfusion in red biohazard container in dirty utility area.
2. Resume previous IV fluids. If IV site may be needed for additional transfusions, then maintain as a PIV lock.
3. Take post-transfusion vital signs (T-P-R & BP) within 15 minutes of completion of the transfusion and record on the Transfusion Record Form.
4. Review and verify Transfusion Record Form is complete with all appropriate signatures, dates and times. Unlicensed personnel may collect vital sign data; however, all vital signs must be reviewed and initialed by the RN. Place original in chart and send yellow copy to Blood Bank via pneumatic tube . If no access to pneumatic tube send via interdepartmental mail .

E. Transfusion Reaction
1. Stop the transfusion immediately if any symptoms of a reaction occur. Immediately switch from blood infusion to saline and get specific treatment orders for reaction from physician. Mild urticaria, hives, or an increased of temperature less than 2^{0}F (or 1^{0}C) alone may not be deemed a sufficient indication by the physician to discontinue the transfusion. All other symptoms require the stopping of the transfusion and proceeding with steps 2, 3 ,4 and 5.
2. Immediately, visually check the patient armband, blood product unit label and transfusion record form, to verify that this is right patient, right blood product, right patient medical record number, and that all information matches the patient arm band, blood component unit label and the Transfusion Record Form.
3. Call the Blood Bank for instructions on proceeding with a transfusion reaction work-up.

4. Order a transfusion reaction work up. Complete and sign the Transfusion Record Form and return yellow copy of the Transfusion Record Form and the blood component bag with all blood tubing, tags and fluids to the blood bank (place in biohazard bag for transport from patient unit to the blood bank.) Transfusion Reaction Record is completed by the Blood Bank. Nursing to document in the EMR.
5. For general information regarding specific transfusion reaction, see addendum. There is the possibility of delayed hemolytic reaction. This type of reaction most frequently occurs between 3-14 days post-transfusion.
   a. **Transfusion Associated Circulatory Overload (TACO)**
      Definition: Infusion volume that cannot be effectively processed by the patient either due to the high infusion rate and /or volume or an underlying cardiac or pulmonary pathology
      Signs and Symptoms: New onset of exacerbation of ≥ 3 of the following within 6 hours of transfusion:
         Acute respiratory distress (dyspnea, orthopnea, cough)
         Evidence of positive fluid balance
         Elevated brain natriuretic peptide (BNP)
         Radiographic evidence of pulmonary edema
         Evidence of left heart failure
         Elevated central venous pressure (CVP)
   b. **Transfusion Related Acute Lung Injury (TRALI)**
      Definition: Acute hypoxemia with PAO2/fraction of inspired oxygen [FIO2)] ratio of 300mm HG or less combined and chest e-ray showing bilateral infiltrates in the absence of left atrial hypertension (ie, circulatory overload)
      Onset of TRALI is abrupt in association with transfusion
      Signs and Symptoms:
         No evidence of Acute Lung Injury (ALI) prior to transfusion
         Acute Lung Injury onset during or within 6 hours of transfusion
         Hypoxemia defined by any of these methods:
         PaO2/FIO2 ≤ 300mm Hg
         Oxygen saturation is < 90% on room air
         Other clinical evidence:
         No evidence of left atrial hypertension (i.e. circulatory overload)
         No temporal relationship to an alternative risk factor for Acute Lung Injury during or within 6 hours of completion of transfusion
   c. **Transfusion Associated Dyspnea (TAD)**
      Definition: Respiratory distress within 24 hours of transfusion that does not meet the criteria of TRALI, TACO or allergic reaction. Respiratory distress should not otherwise be explained by a patient's underlying or pre-existing medical condition.
      Signs and Symptoms:
         Acute respiratory distress and occurs within 24 hours of transfusion and TRALI, TACO and allergic reaction and other underlying medical conditions ruled out.

Documentation – Complete the following:

1. Transfusion Record Form
   a. Signatures of personnel starting and stopping transfusion
   b. Signature of personnel verifying patients identity
   c. Date/Time started
   d. Date/Time stopped
   e. Vital signs **before the transfusion starts**, between the first 10 and 20 minutes of the transfusion and within 15 minutes after the transfusion is complete.

f. Consent signed Yes/No
g. If the patient is an infant has the infant blood screen been drawn? Yes/No
h. If blood or blood product is given under anesthesia check the box "□ Given Under Anesthesia see Anesthesia Record". This will direct healthcare providers to vital signs recorded by anesthesia to avoid duplication.

2. EMR on Blood Flow sheet
   a. Document time when unit was hung.
   b. Document normal saline use.
   c. Vital signs recorded at appropriate times as described above
3. Document any patient responses, treatments or further care that is not within normal limits.

Reference:

CDC. (n.d.). Biovigilance Component. *National Healthcare Safety Network (NHSN) Manual* . Retrieved from Center for Disease Control and Prevention: www.cdc.gov/nhsn June 2011 pages 18, 19, & 21

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Community Health Network Transfusion Committee 2011

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Recommendations from Indiana State Department of Health, October 2011

Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
AABB Technical Manual, 17th Edition, 2011

Approved by:	IV NPP Committee	Date:	3/2013
	Infection Control	Date:	5/2013
	Risk Management	Date:	5/2013
	Network Blood Management Officer	Date:	2/2013
Approved:	NPP Steering Committee	Date:	6/12/13

ADDENDUM 1

Complications From The Transfusion of Blood/Blood Products

1. **Hemolytic Reaction: Immediate**
   a. Causes: The patient receives red cells that are ABO incompatible, this results in the hemolysis of red blood cells. It happens most often due to a mismatch of blood rather than a crossmatching problem. The severity of reaction correlates with the amount of blood transfused.
   b. Symptoms: Fever, chills, pain the lower back/legs, chest tightness, dyspnea, nausea, vomiting, flushing, tachycardia, bleeding from a wound/IV site, feeling of impending doom.
   c. Blood Products: Whole Blood, Packed Cells, leukocyte reduced RBC's, washed RBC's, and deglycerolized RBC's.
2. **Hemolytic Reaction: Delayed**
   a. Causes: Patient develops RBC's antibody due to transfusion, the antibody hemolyzes RBC's that are incompatible.
   b. Symptoms: In the hospital, this will be detected as a decrease in HgB/Hct or an increase in bilirubin due to hemolysis of the incompatible red cells. You will usually not see the immediate, acute signs and symptoms.
   c. Blood Products: Whole Blood, Packed Cells, and all RBC products.
3. **Nonhemolytic Febrile Reactions**
   a. Causes: Leukoagglutinins react with WBC's. cytokines in donor plasma or bacterial contamination.
   b. Symptoms: Fever, chills, nausea, vomiting, headache, dyspnea.
   c. Blood components: RBC products, Platelets, FFP.

   Nonhemolytic allergic reaction:
   a. Causes: IgE antibodies
   b. Symptoms: Urticaria, pruritis, erythema, asthmatic symptoms, anaphylaxis, dyspnea and/or laryngeal edema.
   c. Blood Components: All products containing plasma including RBC products, platelet products, fresh frozen plasma, and Cryoprecipitate.
4. **Bacterial Contamination**
   a. Causes: This is a rare complication caused by bacteria in the donor blood, usually gram - negative organisms. Immunocompromised patients are at a high risk.
   b. Symptoms: Chills, fever, vomiting, abdominal pain, hypotension, shock.
   c. Blood Products: Whole Blood, Packed Cells, Platelets, Plasma, and Cryoprecipitate.
5. **Transmitted Diseases**
   a. Causes: HIV, Viral hepatitis, human te cell lymphocyte te virus I/II, syphilis, malaria, babesiosis, etc.
   b. Symptoms: Onset delayed, disease dependent.
   c. Blood Products: RBC products, Platelets, Plasma, and Cryoprecipitate.

ADDENDUM 1 PAGE 2

Complications From The Transfusion of Blood/Blood Products (continued)

6. **Circulatory Overload**
   a. **Causes:** The volume or rate of infusion exceeds the circulatory system's capacity. Usually seen in patients with underlying cardiac, renal or pulmonary disease; elderly or very young; or massive transfusion (defined as 10 or more units of blood in a 24-hour period.) The possibility of overload can be decreased by the use of packed cells rather than whole blood, an infusion pump and slow rate of infusion, and administration of diuretics as ordered, and transfusion of patients in an upright position.
   b. **Symptoms:** Usually have gradual onset and correlate with the amount of fluid infused; dysopia, cough, pulmonary congestion/edema, neck vein distention, tachycardia, peripheral edema.
   c. **Blood Products:** RBC Products, platelets, Plasma.
7. **Pulmonary Embolism**
   a. **Causes:** Air, clot or foreign material entering the bloodstream via the tubing. Blood filters aid in prevention of emboli.
   b. **Symptoms:** Sudden chest pain, dyspnea, cough, hemoptysis, anxiety, and hypotension.
   c. **Blood Products:** RBC Products, Platelets, Plasma, and Cryoprecipitate.
8. **Hypothermia**
   Blood is stored between 1-6° C (33-43° F) compared to a person's blood with a normal temperature of 37° C. The rapid infusion of large quantities of cold blood especially through a central catheter directly into the right atrium can cause a patient to become hypothermic and result in decreased heart rate, blood pressure, cardiac output, coronary blood flow and ultimately cardiac arrhythmia's and arrest. The use of a blood warmer should be strongly considered with these patients.
9. **Acidosis**
   An anticoagulant solution, usually Citrate-Phosphate-Dextrose (CPD), is added to the blood as it is collected. The pH of CPD solution is 5.6, but the buffering action of Whole Blood (7.4) produces a final pH of 7.1 in freshly donated blood. As blood is kept in storage, despite the hypothermic conditions, anaerobic metabolism occurs with the end products being lactic and pyruvic acids. Thus, blood stored for two days has a pH of 6.9 and continues to decrease to 6.5 after 14 days of storage. The low pH of stored blood usually causes no difficulty because it is diluted with the patient's own blood.
10. **Citrate Toxicity and Hypocalcemia**
    The citrate added to stored blood is a calcium-binding agent to prevent coagulation during storage. Normally the excess citrate is metabolized in the liver and excreted in the urine. Toxic levels of citrate accumulate when this process is ineffective because of impaired hepatic and/or renal function, or in massive transfusion. The additional citrate binds ionized calcium in the recipient's blood, which can lower the serum ionized calcium level to the point of depressed cardiac contractility.
11. **Hyperkalemia**
    Potassium levels in stored blood rise gradually as potassium is released into the plasma by red cells lysis. The American Association of Blood Banks reports that the average amount of Potassium in one unit of 21-day old Whole Blood is 4mEq. This does not normally cause problems, except rarely in patients with impaired renal function.

ADDENDUM 3

BLOOD PNEUMATIC TUBE TRANSPORT

Mid America Clinical Laboratories
Indianapolis, IN 46219

REQUEST	RECEIPT
Patient Information: Full Name, MR#, Room #, or Addressograph **BB ID #, if applicable**_____	**I have received the ordered products and have verified acceptable condition.** Initials _____ Date/Time _____
Product Requested: _____ **Quantity:** _____ **Tube Station:** _____ **Phone #:** _____ **Initials:** _____ **Send request form via pneumatic tube.**	**IMMEDIATELY UPON RECEIPT OF PRODUCT, RETURN THIS COMPLETED FORM TO BLOOD BANK VIA PNEUMATIC TUBE.**

Date/Time Product Sent: _____ To be completed by Blood Bank
If requested product is not received within 30 minutes, call the Blood Bank.

COMMUNITY HOSPITALS OF INDIANA, INC.

1500 N. RITTER AVENUE
INDIANAPOLIS, IN 46219

INSTRUCTIONS TO PATIENTS RECEIVING BLOOD OR BLOOD COMPONENT TRANSFUSIONS

Your physician has requested that you be transfused with a blood product. While the great majority of blood transfusions are accomplished without complications, a small number of persons who receive blood may experience one or more of the following symptoms within a few hours of receiving the blood product:

1. Hives
2. Itching of skin
3. Redness or flushing of skin
4. Fever or chilling sensation
5. Shortness of breath
6. Very dark or black urine

These symptoms will usually disappear in a matter of hours but report them to your physician as soon as possible.

During the next 2-3 months, if you develop any onset of fever/chills, fatigue, aching pains, or yellow skin color please contact your physician. Any other change in your condition should also be reported right away.

The symptoms above may not be a complete list of possible adverse effects of blood transfusions. You should call your physician regarding any other problem or symptom.

Date:_____

Signature: _____

Community
Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE **NPP#: I-14, B-02**
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH **Page 1 of 2**
CANCELS: 8/30/09 **EFFECTIVE: 5/23/12**

Approved For:
☒ CHE ☒ CHN ☒ CHS ☒ TIHH

TITLE: BLOOD, UNCROSSMATCHED

Performed by: RN, LPN, Administrative Partner, EMT-P, EDCT, PSP And PST

Purpose: To outline the process for obtaining blood and blood products before completion of crossmatch testing.

Policy Statements:
1. The record will contain a signed statement from the ordering physician indicating that the clinical situation was sufficiently urgent to require release of blood.

General Information:
1. Blood Bank never releases red blood cells solely on a blood type based on a historical record.
2. The Blood Bank stock O-Rh-negative red blood cells for emergency release.
3. The blood bank stocks AB or A plasma for the emergency release of plasma.
4. If O Rh-negative red blood cells are unavailable, then O Rh-positive red blood cells may be used after consultation with the Blood Bank Medical Director and/or attending physician.
5. If the ABO of the patient is determined before compatibility testing is completed, the Blood Bank will switch to ABO compatible components.
6. The Blood Bank Medical Director and the attending physician are notified by Blood Bank immediately of any abnormal testing results that may affect patient safety.

Equipment: None

Procedure:
1. Request Emergency Release of Blood when the physician deems that the need for blood and blood components is necessary prior to the completion of compatibility testing
2. Place order in the computer for blood products requested.
3. Obtain specimen for crossmatch as soon as possible.
4. Call the Blood Bank and inform them for the need for Uncrossmatched blood and give the following information (if available)
   A. Patient name
   B. Patient date of birth
   C. Medical Record Number
   D. Physician's Name

E. Number of units requested.

3. Obtain the number of requested units from the Blood Bank along with the transfusion record form. NOTE: Each has a bright orange Uncrossmatched label on each unit of blood.
4. Obtain physician signature for the transfusion of Emergency Release.
5. Administer blood per Blood Administration Policy I-014 B-01, "Blood Component Administration".
6. Place original copy of the Transfusion Record Form on the patient's Medical Record Chart and return the 2nd copy to Blood Bank.

Documentation Guidelines:
Document blood administration in electronic medical record and complete Emergency Release Transfusion Record Form

References: Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
AABB Technical Manual, 17th Edition, 2011

Approved by:	IV Advanced Practice	Date: 4/30/12
	Risk Management	Date: 3/21/12
	Infection Control	Date: 2/29/12
Approved:	NPP Steering Committee	Date: 5/9/12

BB.Issue.1.0 Emergency Release of Blood Components

STATEMENT OF PURPOSE

To outline steps to be taken for release of:

a) Uncrossmatched red cells in an emergency situation;
b) Release of plasma and platelet products when an ABO/Rh type is not available.
c) Product selection for Neonatal Emergency Release.

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.ABO/Rh.1.0	ABO Blood Grouping
BB.ABO/Rh2.0	Rh testing – D and Weak D
BB.IAT/DAT.1.0	IAT – Indirect Antiglobulin Testing
BB.TYSC/TRBC.1.0	Compatibility Testing – Required Testing
BB.Issue.2.0	Dispensing of Blood Components
BB.TYSC/TRBC.6.0	Selection of and Indications for Products for Transfusion
BB.Issue.8.0	Preparation of Emergency Release Container

SPECIMEN

EDTA or Clot tube as described in BB.Spec.1.0

MATERIALS

Emergency Release Container in BB refrigerator:

- 2 to 4 units of O negative red cells
- TRF with completed Emergency Release Block
- Orange Uncrossmatched Blood stickers
- Labeled segments from each issued unit
- Optional: Make a Xerox copy of each unit label in the container to scan when the emergency release units are allocated and issued after crossmatch is complete.

PROCESS

I. **Neonatal Emergency Release**

In the event that blood is need emergently for a neonate, the following product will be released:

- O negative
- Irradiated
- CMV negative
- Freshest unit available, preferable less than 5 days.
- If irradiated and or CMV negative blood is not available, contact the transfusion physician on possible product substitution, as in CVM not required due to red cells being leukoreduced.

II. **MACL Staff Available**

A. **Blood Product Selection**

1. Based upon available history, if the patient has special needs, then immediately consult Medical Director/pathologist on call. If history indicates patient has antibodies, notify ordering physician immediately of unavailability of compatible product. However, **DO NOT REFUSE** to give potentially incompatible product if warranted.
2. Each Blood Bank will routinely stock at least 2 units of O negative red cells for Emergency release.
3. If O negative blood is unavailable, do not delay releasing blood, but issue O positive red cells
4. O positive blood should not be given to women less than 55 years of age or pediatric patients unless Medical Director and/or patient's physician have been consulted
5. **NEVER** give Red Cells Products based on historical type.
6. If the contents of the Emergency Release Container are transfused, the container needs to be restocked at the earliest time possible. See BB.Issue.8.0 Preparation of Emergency Release container.

B. **Emergency Release No Specimen Available**

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request: Patient name MR# Transfusing physician Number of units	**Patient information may not always be available. In emergency situations gather as much identifying information as available.**
3	State need for blood bank specimen as soon as possible.	

4	Remove either of the following: • Emergency Release Container • 2 units of either O neg or O positive blood (dependent on the age and sex of the patient)	See BB.ISSUE.8.0 Preparation of Emergency Container.
5	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
6	Complete Emergency Release Block of the Transfusion Record Form.	
7	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
8	Issuing tech signs "Issued By" line of Emergency Release Block.	
9	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
10	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number • Unit type • Exp. date	
9	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.

C. Emergency Release – Specimen Available

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request the following information: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.

4	Select type specific red cells if there is current TRBC or TYSC order.	• A current specimen is one drawn within the last 3 days. Order as additional red cells. • Perform an eXM if IAT is negative. • If patients requires AHG crossmatch, contact pathologist and/or attending physician with patient's history.
6	If antibody screen was positive, or patient has a history of positive antibody screen, retain one segment from each unit. Label segment with unit number.	
7	Complete "Emergency Release Block" of Transfusion Record Form.	Up to 4 units may be initially released. **(Exception:** Surgery may be given more depending on circumstances.)
8	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
9	Place orange "Uncrossmatched Blood For" label on each unit.	
10	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
11	Issuing tech signs "Issued By" line of Emergency Release Block.	
12	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
13	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number • Unit type • Exp. date	
14	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.
15	Upon completion of testing: • Enter testing results in computer • Dispense units in the computer • Unit comment:";ISUN"	ISUN = Units issued Uncrossmatched.

D. Emergency Release – Testing and Paper Work Completion

Step	Action	Notes
1	**Perform** ABO/Rh immediately upon receipt of a properly labeled specimen.	If unable to obtain specimen due to patient demise, enter comment in patient history (e.g., "Patient specimen never received for crossmatch.") See computer steps.
2	**Perform** antibody screen. If negative, **allocate** units and **electronically crossmatch** emergency released units. Notify floor of completed antibody screen results.	If additional units are ordered, select ABO compatible units and continue with electronic crossmatch.
3	**--If positive antibody screen results are obtained, notify requesting physician immediately.** **--If physician wishes to continue with the transfusion, ensure yellow copy of transfusion record form has been signed by that physician.** **--If physician decides to continue transfusing, perform gel crossmatch using segments from units that were emergency released.** **--If crossmatch incompatible, notify physician IMMEDIATELY.** **--Proceed with antibody identification.**	**"Contact Supervisor/Designee and Medical Director."** **Enter** a BBCMT comment to indicate name of physician called, date, time, and initials of tech entering comment. **Write** same comment on the requisition: name of physician notified, date, time and initials of tech doing the notifying.
4	**Verify** that a type and crossmatch has been ordered.	
5	**Receive** orders.	
6	**Record** patient results in the computer.	
7	**Discard** printed Transfusion Record Forms after allocation of units and crossmatch results are entered.	**Hand written Transfusion Record Form is the permanent record.**
8	**Issue units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	See BB.Issue.2.0 Dispensing of Blood Components.
9	Paper work follow up: • Keep pink copy in view for reminder of follow up till yellow copy received from nursing unit. • Obtain yellow copy of Transfusion Record Form with physician's signature. • File yellow copy in blood file labeled "Emergency Release.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

II. MACL Staff Unavailable – Sites without staffing 24/7

NOTE: Red cell products shall be made accessible for emergency transfusion at all MACL hospital based lab sites that are not staffed continuously. These blood products must be easily identifiable by non MACL staff and must be labeled appropriately. The necessary accompanying paperwork should be stored with the red cells.

A. Blood Product Selection and Release – Utilizing Emergency Release Container

Step	Action	Notes
1	Patient requires emergency transfusion at a time when the laboratory is not staffed.	
2	An appropriately labeled blood bank specimen should be obtained on the patient prior to transfusion.	
3	An order for crossmatch must be placed in the hospital computer system.	
4	Nurse or physician enters blood bank area and removes the "Red Cells for Emergency Transfusion" container from the blood bank refrigerator.	
5	Following the "Nursing Instructions for Emergency Transfusion", the blood transporter (nurse or physician) completes the indicated portion of the Transfusion Record Form.	
6	Transporter (nurse or physician) fills out patient information on the orange "Uncrossmatched Blood For" label.	
7	Transporter (nurse or physician) takes top two copies of the Transfusion Record Form with the units and leaves the bottom copy for the laboratory staff.	
8	Transporter (nurse or physician) will obtain the ordering physicians signature in the appropriate area of the Transfusion Record Form. The signed copy MUST be returned to the blood bank.	
9	Units that are not transfused must be returned to the blood bank refrigerator within 30 minutes. Accompanying paper work must also be returned.	

B. Emergency Release Specimen Work Up by MACL Staff

Step	Action	Notes
1	Perform blood type, antibody screen and crossmatch testing on the pretransfusion specimen.	Send the specimen to CTS if staff is not present to perform testing.
2	Notify patient care area of the results when testing is completed.	

3	Discard the Transfusion Record Forms that are generated during result entry If the units have been transfused. **The handwritten Transfusion Record Form is the permanent record.**	If the units have been returned to the blood bank, they may be relabeled with the computer generated Transfusion Record Forms.
4	**Issue any transfused units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	
5	Obtain the yellow copy of the Transfusion Record Form that is completed with the physician's signature documenting the emergency release. File appropriately.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

III. Plasma or Platelet Products

- If MACL staff is unavailable, patient care staff follows "Nursing Instructions for Emergency Transfusion".

Step	Action	Notes
1	Receive call requesting plasma products.	FFP, Cryo or Platelets
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	Perform history check, if no historical type is available, issue the following: **FFP- type AB** **Platelets – any type available** **Cyroprecipitate- A or O**	**NOTE: Up to 500 mls of incompatible plasma may be given in 24 hours without notification of Medical Director.**
4	State need for blood bank specimen as soon as possible.	
5	Upon receipt of properly labeled specimen, perform blood type and proceed with giving type compatible products.	

COMPUTER STEPS

1. Completing Sample Testing Results in Function Blood Order Processing after Emergency Issue

Step	Menu Selection	Action	Notes
1.	Blood Order Processing	Enter patient's MR# in the "Value" field and select appropriate patient.	M# must be entered from patient's specimen tube.
2.		Select Order Selection tab.	
3.		Select accession number.	
4.	Patient Specimen	Perform and enter patient test results.	See computer steps in BB.ABO/Rh.1.0 ABO Blood Group Testing BB.ABO/Rh.2.0 Rh Testing- D and Weak D BB.IAT/DAT.1.0 IAT-Indirect Antiglobulin Testing. **If unable to obtain specimen due to patient demise, order BBCMT in "add spec. test" field. Free text ; Patient specimen never received for crossmatch. Add date and initials of tech commenting.**
5.	Allocation	Press **Allocation tab.** Place cursor in **Unit #** field. Enter unit number of each unit issued. Sites that make a copy of emergency kit unit labels will be able to scan the unit number from the Xerox copy. Press **Select.**	Perform crossmatch methodology required for patient. BB.TYSC/TRBC.1.0 Compatibility Testing – Required Testing BB.TYSC/TRBC.2.0 Electronic Crossmatch BB.TYSC/TRBC.3.0 Crossmatch - IS BB.TYSC/TRBC.4.0 Crossmatch- AHG
6.		Click on **Save** button.	

REFERENCES

Standards for Blood Banks and Transfusion Services, AABB, Current Edition.
AABB Technical Manual, Current Edition.

WRITTEN BY: Pat Smith, MT (ASCP)

IMPLEMENTATION DATE: January, 2000

BB.TYSC/TRBC.6.1 NURSING GUIDE FOR RED CELL SUBSTITUTUIONS

The following explanation may be sent with red cell units that are non ABO/RH identical.

Whenever there is a blood shortage from our blood suppliers (Indiana Blood Center or American Red Cross), the possibility exists that patients may receive a unit different from their own blood type. The following chart lists the acceptable blood type substitutions.

Red Cell Product Transfusion

A. Substitution Table - **ABO**

Patient Type	Acceptable ABO TYPE
O	O
A	A, O
B	B, O
AB	AB, A, B, O

B. Substitution Table – **RH**

Patient Type	Acceptable Rh TYPE
Rh positive	Rh positive or Rh negative
Rh Negative	Negative OR positive if inventory warrants with the following guidelines:
	1. Patient is a male 2. Female older than 55 years of age or consent has been obtained from the Medical Director. 3. Patient does not have the Anti-D antibody.

BB.Recv.4.0 OBTAINING BLOOD COMPONENTS

STATEMENT OF PURPOSE

The purpose of this document is to outline the process for ordering blood components from suppliers.

SCOPE

This process applies to all Mid America Clinical Laboratory Blood Banks.

RELATED DOCUMENTS

BB.Gen.2.0	Minimum Inventory (Site Specific)
BB.Recving.1.0	Receipt, Inspection, Storage and Disposal of Blood Components and Reagents
BB.Misc.5.0	Indiana Blood Center Critical Policy

PROCESS

Standing Orders are established for all hospital sites with our blood suppliers. These standing orders apply to red cell and platelet products. Standing order blood components for sites in the Indianapolis area will be delivered to the CTS (Centralized Transfusion Service) for processing and distribution to hospital sites. Standing orders may be altered by either CTS or the respective hospital site when inventory needs change.

If a site hospital changes a standing order scheduled to be delivered to CTS, CTS is to be notified of the change. If CTS does not receive a scheduled standing order, they notify the site hospital.

When red cell products or platelets are needed immediately, the hospital site should contact the blood supplier directly and have the blood product delivered directly to the hospital site.
Plasma products and cryoprecipitate should be ordered by and delivered directly to the hospital site.

I. Placing Orders with IBC (Indiana Blood Center)

Step	Action	Notes
1	Phone distribution department,	

2	When placing the order, the following information will be given: • Callers name • Facility's name • Product needed • ABO/Rh type needed • Number of units for each product/type needed. • Type of special run o Express: Orders are filled and picked up from IBC within 1 – 1 ½ hours from time order is placed o Stat: Stat orders will be filled and picked up from IBC within thirty (30) minutes form the time the order is packed or delivered immediately following packing into IBC STAT car. o Standard: Standard orders have a three hour window form pickup to delivery.	
3	Document order on Blood Supply Order Log, (BB.Recving.4.1) or any other documentation method.	
4	In the event of a disaster, IBC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Fort Wayne)

Step	Action	Notes
1	Phone distribution department,	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Louisville)

Step	Action	Notes
1	Phone distribution department,	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

REFERENCES

IBC Disaster Plan for Blood Product Supply.
IBC Blood Services Guide.
ARC Disaster Plan for Blood Product Supply.

WRITTEN BY: Kim Coors, MT (ASCP) BB

IMPLEMENTATION DATE: April 2000

BB.GEN.8.0 Verbal Orders for the Provision of Blood Components

STATEMENT OF PURPOSE

During emergent situations, there may be times when the entry of orders into the hospital order system may not be able to be completed in a timely manner. During these rare times, the blood bank may take verbal orders over the phone. After the crisis situation has been resolved, the nursing unit along with the ordering physician will ensure that written/electronic orders are sent to the blood bank per CLIA regulations. (42CFR 493.1241(c))

The purpose of this document is to outline the steps necessary to take when receiving verbal orders for the provision of blood components.

SCOPE

This protocol pertains only to Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.GEN.8.1 Verbal order form

PROCEDURE

The procedure for receipt and processing of verbal orders from surgical areas will be as follows:

I. Receipt of the verbal order:

A. Associates answering the phone in the blood bank will take the following information and document on the Verbal order form BB.GEN.8.1:

1. Patient's full name
2. Medical Record number
3. Blood Bank ID number if applicable
4. Patient's date of birth
5. Ordering physician's first and last name
6. Name of person giving the verbal order
7. Location
8. Component(s) being requested
9. Number of units requested for each component type.

B. Placing orders into Sunquest:
   1. In function REH, place the order for each component ordered and the amount requested
   2. Place the Sunquest order labels on the Verbal Order form BB.GEN.8.1

C. Processing the orders:
   Orders will be processed in Misys in the standard manner.

D. Follow up:
   1. Upon the completion of the case, the OR team will place the orders in the hospital order system.
   2. The blood bank associate will take the printed order requisition(s) from the printer and attach to the Verbal Order Form BB.GEN.8.1.
   3. The printed orders will be retained in the blood bank for a period of at least 3 months.

REFERENCES

42 CFR 493.1241(c):
AABB Standard 5.11.1, 27th Edition,
The Interpretive Guidelines §482.23(c)2(i) and §482.23(c)3

MACL Verbal Order Form BB.GEN.8.1

Patient Name:		
Medical Record Number		
Patient's DOB		
BBID(if Applicable):		
Surgical location/Rm #		
Ordering Physician: (First and Last Name)		
Name of person giving order		
Component (✓ if ordered)		Number of units
Red Cells		
Platelets		
Plasma		
Cyro		
Attributes: ( ) Irr ( ) CMV negative ( ) HgbS negative ( ) Other:_____		

History Checked by:_____

ABO/RH:_____ **AG/AB:_____**

Auto/DD units:_____ **Comments:_____**

Retype ABO/RH:_____

Place Sunquest Order labels Here:

Upon receipt of written orders attach to back of this form.

BB.Misc.4.0 Critical Blood Supply Policy

STATEMENT OF PURPOSE

To outline the steps to be taken Mid America Clinical Laboratories when there is a notification from the blood supplier of a "Critical Blood Shortage".

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

POLICY

A. The site blood supplier notifies the Transfusion Service(s) (Medical Director, Blood Bank Supervisor or designee) that the blood supply is at a critically low level.

B. The supervisor/designee of each blood bank performs on immediate inventory of products on hand and communicates this to the Medical Director.

C. The Laboratory Medical Director contacts Transfusion Committee Chair(s) and together with the Blood Bank Supervisor(s) reviews immediate needs for blood products (crossmatch requests) needed for upcoming surgery. If a decision is made that current blood inventory may not meet anticipated need, elective surgical cases may need to be postponed or rescheduled. In this case the following people/departments are contacted:

1. Surgeons involved
2. Surgery Managers
3. Surgery Scheduling
4. Corporate communications officer
5. Chief of Medical Staff

Depending on the urgency and projected length of the blood shortage, consideration may be given to an urgent email notification of the entire Medical Staff.

D. Emergency requests for blood (intraoperative, ED, Labor and Delivery) should be immediately crossmatched and issued. If crossmatching is not possible due to the urgency of the request, follow policy for emergency release of blood.

E. With the resolution or easing of the blood shortage, the contacted individuals in section C shall be informed/updated.

4. REFERENCES

CHI Critical Blood Supply Policy
St. Vincent Hospitals and Health Services, Carmel and Indianapolis, Blood Shortage Notification Flow Sheet
St. Vincent Hospitals and Health Services Blood Shortage Memorandum

WRITTEN BY: Dr. Terry Cudahy and Dr. David Powers

IMPLEMENTATION DATE: April 2000

BB.GEN.2.0 **Minimum Inventory**

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

- **Community Hospital East**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	20	10	20	10					
Plasma	10		10		10		10		
Cryo			2 pools						
Platelets	1 apheresis available except for Sunday								

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.
- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

BB.GEN.2.0 Minimum Inventory

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

MINIMUM INVENTORY PER SITE

- **St. Vincent - Indianapolis**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	100	40	100	20	15	6			
RINF	4	4	4						All CMV Negative & prestorage leukoreduced.
Plasma	20		30		10		20		
Cryo	4 pools		4 pools		4 pools		10 single cryo 4 pools		*Pools =pool of 5 units
Platelets	• 4 Platelet pheresis, any type for general population. • 2 A+/= platelet pheresis, for trauma • 1 AB +/= or A+/=, CMV negative, for neonatal use.								2 platelet phereis for general population to be CMV negative
Rh Immune Globulin	25 vials								

- **St. Vincent – Women's**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	8	10	6					
RINF		4							CMV Neg, LR, IRR
Plasma			8		2		4 adult 8 pedi		
Cryo			1 pool				5 single		
Platelets	1 A or AB								
Rh Immune Globulin	25 vials								

- **St. Vincent - Jennings**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	6	2					

- **St. Vincent Salem**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	8	4					
Rh Immune Globulin	2-5 vials								

- **St. Vincent – Fishers (North East Medical Center)**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL		4*							2 CMV neg & Irr
Rh Immune Globulin									

- **St. Vincent - Carmel**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	4		2	0	0	
RNF		1							
Plasma	4		4				6 - 1 AB infant		
Cryo	5		5						
Rh Immune Globulin	2 boxes of 10 vials each								

- **St. Vincent - Mercy**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	7	4					
Plasma							6		
Rh Immune Globulin	4								

- **St. Vincent - Randolph**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	4	3	4	2	1	1			
Plasma							4		
Rh Immune Globulin	10								

- **IOH**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	5	6	6	4					
Plasma							6		

- **St. Vincent - Dunn**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	4*	6	4					• 2 CMV neg
Plasma							4		
Rh Immune Globulin									

- **St. Vincent - Anderson**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	22	6	22	6	5	2	2	2	
Plasma	6		6		6		6		
Rh Immune Globulin	10								

- **St. Vincent – St. Joseph Kokomo**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	4	10	4	2				
Plasma	6		6		4		4		
Rh Immune Globulin									

MACL Minimum Inventory

- **Community North**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	25	10	25	4					
RINF		1							<5 days, CMV=,LR,IRR pedi bags attached
Plasma	20		20		8		8 (at least one unit of ped plasma)		
Cryo			10 or 2 pools of 5				1 single or 1 pool		
Platelets	1 AB or A Rh neg or positive								CMV=,LR,IRR, pedi bags attached

- **The Indiana Heart Hospital**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	6	4					
Plasma	20		20		4		4		
Cryo	4		4		4				
Platelets	2*								

* 2 units of apheresis platelets will be kept on site Monday-Friday during normal surgical hours (6:30am-5pm). After normal hours, weekends and holidays a minimum of one unit will be kept on hand, if supply is available. Standing order of platelets is delivered on the following time table: Monday 2 units, Tuesday and Wednesday 3 units, Friday 1 unit. If patients are stable and the need is not emanate for the use of platelets, in order to conserve the product, the blood bank will not order additional units of platelets to arrive before the standing order.

- **Community Hospital East**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	20	10	20	10					
Plasma	10		10		10		10		
Cryo			2 pools						
Platelets	1 apheresis available except for Sunday								

- **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.

Minimum Inventory

- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

WRITTEN BY: Beth Hughes

IMPLEMENTATION DATE: Jan 2000

BB.GEN.7.0 RESOURCES - STAFFING

STATEMENT OF PURPOSE

This policy defines the determination of staffing levels within the blood banks and also defines the location and determination of job descriptions and qualifications.

SCOPE

This policy applies to all Mid America Clinical Laboratories blood banks

RELATED DOCUMENTS

MACL QUALITY PLAN

POLICY

A. Staffing requirements will be determined by the following criteria:
   1. Workload as determined by the IEB and workload recording programs in Sunquest.
   2. Overtime paid as determined by the payroll department.
   3. Staffing requirements for all shifts including weekends, holidays and vacations.
   4. The above criteria will be reviewed by the VP for Hospital Operations, HR and the site supervisor when staffing issues arise.

B. Role summaries are written and maintained in the Human Resources Department of Mid America Clinical Laboratories.
   1. Role Summaries are written by the Human Resources Department along with input from Directors and Supervisors.
   2. Job descriptions are maintained in the Human Resources Department residing at the Regional Facility on Shadeland Avenue.

C. Contingency Plans for staffing may include the following:
   1. Staff from other sites may be deployed to the area in need.
   2. Workload may be shifted to other sites (i.e. routine work may be sent to another location).
   3. Antibody identification and problem patients may be sent to the Reference Lab at Indiana Blood Center.

RESOURCES - STAFFING

WRITTEN BY: Kim Coors, MT(ASCP)BB

IMPLEMENTATION DATE: Feb 2003

QA.GEN.1.5 MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

I. Mission

Our mission is to be the leading Indiana provider of quality clinical laboratory services achieved through the expertise, commitment, and creativity of our associates.

II. Scope of Services

Laboratory Testing Facilities

Mid America Clinical Laboratories includes a network of Hospital-Based Laboratories, Laboratory Service Centers, Point-of-Care Testing (POCT) services, and a Regional Reference Laboratory.

Hospital-Based Laboratories—The Hospital-Based Rapid Response Laboratories (RRL) perform stat and some routine testing 24 hours a day, 7 days a week, as necessary for appropriate patient care at each hospital location. Testing at these laboratories includes the following disciplines:

- Chemistry
- Coagulation
- Hematology
- Immunohematology (Blood Bank)
- Rapid and Routine Microbiology
- Urinalysis

Regional Reference Laboratory—The Regional Reference Laboratory performs routine and esoteric testing in the following clinical pathology disciplines:

- Chemistry
- Coagulation
- Gynecologic Cytology
- Hematology
- Immunohematology (Blood Bank)
- Immunology

- Microbiology (including Bacteriology, Mycology, Virology, Parasitology and Mycobacteriology)
- Molecular Diagnostics
- Urinalysis

Much of the testing at the Regional Reference Laboratory is performed overnight, to better support patient care by allowing at most 24-hour turnaround time for most routine, and some esoteric tests. Hours of service vary by department or testing area. This facility may be contacted through Customer Services.

Point-of-Care Testing—Point-of-Care Testing is performed and/or managed in many locations, including hospital patient care units, emergency departments, outpatient clinics, surgery centers and MACL Patient Care Centers (PCCs). MACL provides POCT oversight management or assistance to hospital clients to ensure all regulatory requirements are met. These services include: selection of POCT devices, training, review of data, performance of linearity/correlation studies, procedures, logs, investigation of new methods, proficiency testing selection and review, etc. A certified medical technologist and several POCT service representatives staff the department to support this program.

Laboratory Accreditation and Quality Assurance—MACL is accredited by the College of American Pathologists (CAP) and, for the St. Vincent Indianapolis Blood Bank, the American Association of Blood Banks (AABB). Both the CAP and the AABB are deemed accrediting agencies for the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Clinical Laboratory Improvement Amendments (CLIA), which is the set of Federal regulations covering clinical laboratory practices. Additionally, MACL services are monitored and approved by the Indiana State Department of Health (ISDH) and the Food and Drug Administration (FDA).

Board-certified pathologists direct all laboratory activities, providing medical and technical support services on a full-time basis. Well-trained and competent medical technologists, cytotechnologists, analytical scientists, medical laboratory technicians, and lab assistants enable MACL to provide precise and accurate test results. Day-to-day quality and accuracy are assured by internal quality control and external proficiency testing programs, as well as extensive competency assessment protocols. A comprehensive quality management program provides both guidance and monitoring of testing quality and service effectiveness.

Safety—MACL complies with all applicable safety and environmental requirements established by federal, state and local authorities (eg, OSHA, EPA, IDEM, ISDH).

Results Reporting Services—In accordance with regulations governing clinical laboratories and in order to maintain the confidentiality of personal health information, it is MACL policy to release test-related information only to the person who requested the test or to that person's representative.

Computer generated reports are charted in the hospitals or sent to physician offices or outside facilities by the best available means of communication: electronically, by courier, or by mail.

Reference ranges (normal ranges) with interpretation of results as indicated will be included on each patient test report. Because of continuing improvements in methodology and expanding knowledge in clinical interpretation, reference ranges do not remain static in a progressive laboratory. Each report will carry current reference ranges for the specific test.

Alert or critical results are flagged in the laboratory computer system when they exceed the verification range. All alert values are telephoned to the nursing unit or the physician. For those tests with established turnaround times, the laboratory will evaluate the urgency of the test result requested and notify the appropriate nursing unit or physician.

Turnaround times for STAT tests performed on site at the Hospital Based RRLs will be one hour or less from receipt in the laboratory. Turnaround times for routine tests performed by the Regional Reference Laboratory will be less than 16 hours. Most microbiology testing, esoteric testing, and gynecologic cytology will be available in 48 to 72 hours; dependent upon methodology. When appropriate, microbiology preliminary reports are often available after 24 hours.

Rapid Response Laboratory (RRL) Test Availability—Rapid Response Laboratory test menus vary slightly, dependent upon the needs of the facility's patient population and service mix. STAT orders for testing are targeted for result availability within 30 minutes for emergency department (ED) requests and 45 minutes for non-ED requests. The basic RRL test menu includes the tests shown in the table below. Again, this menu varies based on facility need due to patient population and service mix (eg, a facility offering transplant services may require the ability to monitor some transplant drug concentrations in their patients, another location may service patients who do not require some of the tests listed, such as gentamicin).

Rapid Response Laboratory (RRL) Sample Test Menu		
Acetaminophen	CPK	Occult Blood, Gastric
Acetone	Creatinine	Osmolality, Blood/Urine
Alanine Aminotransferase (ALT)	Crossmatch	Phosphorus
Albumin	D-Dimer	Platelet Count
Alcohol	Digoxin	Potassium, Serum/Plasma/Blood
Alkaline Phosphatase	Dilantin	Protein, Total, Blood
Ammonia	Direct Antiglobulin Test	Protein, Total, CSF
Amylase	Drug Screen, Urine (Triage)	Protime (PT, Prothrombin Time)
Antibody Screen	Electrolyte Panel, Blood	PTT (Partial Thromboplastin Time)
Antibody Screen, prenatal	Gentamicin	RBC Count
Aspartate Aminotransferase (AST)	Glucose, Blood	Renal Function Panel
Bacterial Vaginosis (BV)	Glucose, CSF	Respiratory Syncytial Virus (RSV)
Basic Metabolic Panel (BMET)	Glucose, Post Prandial, 2 hour	Rh Typing (includes weak D)
Bilirubin, Direct	Glucose Tolerance (various)	Salicylate
Bilirubin, Direct-Neonatal	Gram Stain	Sedimentation Rate
Bilirubin, Total	Group A Strep Screen	Sodium, Blood
Bilirubin, Total-Neonatal	HCG, Qualitative, Blood	Specific Gravity, Urine
Blood Type	HCG, Qualitative, Urine	Tegretol/Carbamazipine
BNP	HCG, Quantitative, Serum	Trichomonas Rapid Test (TRS)
BUN	Hematocrit	Trich Prep
Calcium	Hemoglobin	Troponin I
Calcium, Ionized	Hepatic Panel	Type and Crossmatch
Carbon Dioxide (CO2)	HIV 1/2 (Suds) Needlestick Protocol	Uric Acid, Blood
Carbon Monoxide (CO)	India Ink Prep	Urinalysis (UA)
CBC (no Differential)	Influenza A & B	Urinalysis Microscopic
CBC with Differential	Iron, Total	Urine, Ketone
Cell Count, Body Fluid	Lactic Acid, Blood	White Blood Cell Count
Cell Count, CSF	LDH	
Cell Count, Joint Fluid	Lipase	
Chloride	Magnesium	
CKMB	Mono Screen	
Clostridium difficile—Rapid	Myoglobin	
Comp. Metabolic Panel (CMET)	Occult Blood, Fecal	

Client Services

MACL recognizes that the laboratory's quality is defined by both technical and service quality. We will continually strive to understand, respond to, and meet the needs of our clients by functioning as their advocate; recognizing and responding to service opportunities and facilitating resolution.

The Client Services Department is available:

Monday – Friday	24 hours/day
Saturday	12:00 AM – 3:30 PM (RRLs take calls after 3:30 PM)
Sunday and Holidays	7:00 AM – 3:30 PM (Closed Christmas Day; RRLs take calls after 3:30 PM)

Client Services addresses all customer inquiries relative to specimen requirements, test results, test information, and duplicate reports or report retransmission, along with other questions and concerns.

Courier Services/Specimen Pick-up

Courier service is designed to meet the needs of our customers for specimen pick-up, and report and supply delivery to hospitals, clinics, physician offices, and nursing facilities throughout our service area.

Patient Care Centers

MACL has more than 20 Patient Care Center (PCCs) throughout Central Indiana. In addition to these locations, outpatient draw sites are located in many of our affiliated hospital locations. Hours for the hospital-based PCC locations are, at minimum, Monday-Friday 8 AM to 5 PM; some locations have Saturday hours. Information on specific locations is available through Client Services and the MACL webpage (www.maclonline.com) These PCCs are staffed with Phlebotomists who are required to complete competencies in age-specific training in phlebotomy and specimen preparation, including annual recertification in all areas. All associates undergo extensive compliance training, which includes coverage of HIPAA requirements.

Beyond these MACL-specific PCC locations, we have numerous in-office phlebotomists placed in clinics and physician practices throughout Central Indiana.

BB.Issue.9.0 Code Blue - Maternity Services CHI Sites

STATEMENT OF PURPOSE

To outline steps to be taken for release products during a Code Blue – Maternity Services.

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks that serve CHN, CHE, and CHS.

MATERIALS

Code Blue Blood Box with

1. **4 units of Red Blood Cells**
   - 4 O negative red cells
   - TRF with completed Emergency Release Block
   - Orange Uncrossmatched Blood stickers
   - Labeled segments from each issued unit
   - Ice packs
   - Patient information label for blood box

   OR
   - 4 electronically crossmatched red cells
   - Corresponding completed TRFs
   - Ice packs
   - Patient information label for blood box
2. **2 units of Plasma**
   - 2 thawed ABO compatible or AB FFP

Corresponding completed TRFs

PROCEDURE

I. **Code Blue – Maternity Services**

Upon receipt of "Code Blue – Maternity Services" either by overhead page or receipt by HBL pager, perform the following:

1. Obtain patient name, Medical record number (if available), and location of patient.
2. Perform a History search and document on order requisition, if available.

II. Blood Product Selection

NOTE: Based upon available history:

If	Then
Patient has special needs: • Irradiated products needed • CMV negative products needed • Hgb S negative products needed • Other needs or the above products are not available	Give irradiated products if available Give CMV negative products if available. Give Hgb S negative products if available. Immediately consult Medical Director/pathologist on call.
Patient history indicates antibodies	Notify ordering physician that • All blood will be emergency released uncrossmatched. • Notification will be given when the crossmatch is completed with the results of the crossmatch

AT NO TIME REFUSE to give products due to patient history. This is to be determined by the ordering physician.

III. Patient has current Type and Screen or Type and Crossmatch

Step	Action	Notes
1.	Crossmatch 4 units of compatible blood.	Set up 4 more red cell units to hold in BB. Keep 4 units of red cells on hold until patient condition resolves
2.	Thaw 2 units of ABO compatible plasma.	Notify unit when available for transportation.
3.	Perform computer functions for crossmatching of blood and thawing of plasma	
4	Label units appropriately.	
5.	Issue units in computer.	
6.	Read and verify units with 2nd tech or lab assistant.	
7.	Prepare Code Blue – Maternity Services or Blood Box a. Label with completed blood box label. b. Place available units in box	If plasma preparation is not completed by the time the transporter arrives, send blood and call unit when plasma is ready.

8.	Release to transporter a. Transport signs "Transported by/received by: line of Unit Transportation block. b. Retain bottom copy of TRF c. Send top 2 copies of TRF with the unit(s)	Transporter is defined as an appropriately trained MACL or any hospital employee. Use copy to help track units and documentation of physician signature.

IV. Patient has Hold Tube available.

Step	Action	Notes
1.	Perform ABO/Rh type on available specimen, if time permits. If unable to perform, proceed to No Current Specimen Available in Blood Bank section.	CHN & CHS: REH T&C with information from hold requisition CHE: OER hold order
2.	Select 4 ABO/Rh compatible red cells units.	
2.	Thaw 2 units of ABO compatible plasma.	Thaw AB plasma if time does not permit testing for ABO/Rh.
3.	Label units with orange uncrossmatched label.	Note: Units are considered uncrossmatch because all BB testing is not compete i.e. IAT.
4	Complete Emergency Release portion of TRF, including "Issued by" line in Emergency Release Block.	
5.	Prepare Code Blue or Blood Box a. Label with completed blood box label. b. Retain 2 segments from each red cell unit dispensed. c. Place available units in box.	If plasma preparation is not completed by the time the transporter arrives, send blood and call unit when plasma is ready.
6.	Transport signs "Transported by/Received by" line of TRF.	Transporter is defined as an appropriately trained MACL or any hospital employee. Use copy to help track units and documentation of physician signature.
6.	Retain bottom copy of TRF.	
7.	Send top two copies of TRF with unit(s).	
8.	Perform IAT.	
9.	Notify nursing unit of completion of testing.	**If positive results are obtained on either antibody screen or crossmatch, notify requesting physician immediately.**
9.	Complete computer entry results.	See BB.ISSUE.1.0 Emergency Release of Blood Components.

V. No Current Specimen in Blood Bank

Step	Action	Notes
1.	Select Emergency Crossmatch units or 4 O negative units.	
2.	Thaw 2 units of AB plasma.	
3.	Label units with orange uncrossmatched label.	
4	Complete Emergency Release portion of TRF, including "Issued by" line in Emergency Release Block.	
5.	Prepare Code Blue – Maternity Services or Blood Box a. Label with completed blood box label. b. Retain 2 segments from each red cell unit dispensed. c. Place available units in box.	If plasma preparation is not completed by the time the transporter arrives, send blood and call unit when plasma is ready.
6.	Transport signs "Transported by/Received by" line of TRF.	Transporter is defined as an appropriately trained MACL or any hospital employee. Use copy to help track units and documentation of physician signature.
6.	Retain bottom copy of TRF.	
7.	Send top two copies of TRF with unit(s).	
8.	Request sample for testing as soon as possible from nursing unit.	

VI. Emergency Release Follow Up

Step	Action	Notes
1	Receive blood bank orders into computer system.	See SOP 1.113 Specimen Receipt and Rejection. Note: CHN & CHS has manual requisitions from OB. The order will need to be ordered in LIS system
2	Perform ABO/Rh, antibody screen and compatibility testing, (if patient is not an electronic crossmatch candidate), using segments from issued units.	If additional units are ordered, select ABO compatible units and continue with crossmatch.
4	Record patient results in the computer.	Refer to: BB.ABO/Rh.1.0 ABO Blood Group Testing BB.ABO/Rh.2.0 Rh Testing – D and Weak D BB.IAT.1.0 IAT- Indirect Antiglobulin Testing BB.TYSC/TRBC.1.0 Compatibility Testing – Required Tests. BB.Issue.1.0 Emergency Release of Blood Components.

3	Notify floor of completed crossmatch results. **If positive results are obtained on either antibody screen or crossmatch notify requesting physician immediately. If physician wishes to continue with the transfusion, an emergency release form stating that testing is not complete must be signed by physician.**	"Contact Supervisor/Designee and/or Medical Director for further instructions."
7	Discard Transfusion Record Forms generated for emergency released units.	Hand written Transfusion Record Form is the permanent record.
8	Issue any units already dispensed in the computer: On the comment line of the Batch Data Entry Screen enter "Emergency release issue" for those units released before crossmatch completion.	See BB.Issue.2.0 Dispensing of Blood Components.

	Notes
1	Code Blue- Maternity Services is used in any emergency situation with a pregnant female who has had a blood loss between one to one and one-half liters of whole blood.
2	All OB/GYN departments at Community Hospitals will draw a BBID labeled pink top tube specimen to be delivered to BB labs for storage upon patient admission.
3	OB/GYN departments will assess the bleeding risk for their patients. Any patient who is moderate risk will have type and screen preformed upon their admission to the floor. Any patient who is high risk will have type and crossmatch preformed with 4 units on hold.
4	**Never give Red Cell Products based on historical type.**
5	The Blood Bank will coordinate transportation of blood products. The house supervisor or code blue nurse should be available for transportation of all blood products needed by OB. Other transporters could include security or utilizing lab assistants, if available, for the delivery of blood products.
6	Do not hold up delivery of Code Blue – Maternity Services red cell products for Plasma products. Plasma products will be delivered to unit when available.
7	In Code Blue – Maternity Services situation 4 Packed RBC's will be kept on hold until patient condition resolves.

REFERENCES

Standards for Blood Banks and Transfusion Services, AABB, Current Edition.
AABB Technical Manual, Current Edition.
Code Blue – Maternity Services protocol established by CHI taskforce headed by Dr. Michelle Murphy based on New York State Obstetrical hemorrhage protocol.

WRITTEN BY: Tara Walters, MT(ASCP)
Kim Coors, MT(ASCP)BB
IMPLEMENTATION DATE: October 15, 2009

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 16

24 HOUR LABORATORY SERVICES

"16. **Laboratory services**: There must be laboratory services available 24 hours per day."

NARRATIVE RESPONSE AND DISCUSSION

The Community Hospital East Laboratory Administrative Director has provided a letter affirming compliance with all ACS lab requirements twenty-four hours per day. The Community Hospital East laboratory performs all standard analyses for blood, urine, and other bodily fluids including micro sampling when appropriate. Additional services include coagulation studies, blood gasses, and microbiology.

Community Health Network

June 9, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital East's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that the Laboratory supports Community East Hospital's effort to complete the "in the process" Level III Trauma Center Requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

We further understand that our role is to ensure that laboratory services are available twenty-four hours per day at Community East Hospital. This includes the standard analyses for blood, urine, and other body fluids, including micro sampling when appropriate. Our lab services also include coagulation studies, blood gasses, and microbiology.

Respectfully,

Kimacka Randle, MLS (ASCP) MSM
Laboratory Manager

Anjali Godambe, D.O.
Laboratory Medical Director

Bahjat S. Chabenne, M.D.
Trauma Medical Director

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 17

POST ANESTHESIA CARE UNIT (PACU)

"17. **Post-anesthesia care unit**: The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment 24 hours per day. Documentation for this requirement must include a list of available equipment in the PACU."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 17 are met with:

1. Letter from Charles Scott Vore, M.D. affirming compliance with requirements.
2. Perioperative Clinical Manager commitment letter.
3. Twenty-four hour call and staffing guidelines.
4. PACU Quality Management Plan
5. PACU general policy
6. Staff qualifications list
7. PACU equipment list

Community Health Network

Community Hospital East
1500 North Ritter Avenue
Indianapolis, Indiana 46219-3095
317-355-1411 (tel)
eCommunity.com

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital East's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this letter is to inform the committee that I serve as Anesthesiology Section Representative. I am pleased to support Community Hospital East's effort to complete the "In the Process" Level III Trauma Center requirements, including participating as a member of the Performance Improvement and Patient Safety (PIPS) Committee. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I confirm that qualified nurses and all necessary equipment are available twenty-four (24) hours per day in the Community Hospital East Post Anesthesia Care Unit.

Respectfully,

Charles Scott Vore, M.D.
Anesthesiology Section Representative

Bahjat Chabenne, M.D.
Trauma Medical Director

Community Health Network

Community Hospital East
1500 North Ritter Avenue
Indianapolis, Indiana 46219-3095
317-355-1411 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D.-Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 26204

Subject: Community Hospital East's Application for "In the ACS Verification Process" for Level III Trauma Center designation

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Clinical Manager of the Post Anesthesia Care Unit. I am pleased to support Community Hospital East's effort to complete the "In the Process" Level III Trauma Center requirements. Subsequently, we will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that qualified nurses and all necessary equipment are available twenty-four hours per day.

Respectfully,

Dorine Lewis RN

Dorine Lewis, RN
Clinical Manger PACU

Bahjat Chabenne, M.D.
Trauma Medical Director

Community Hospital East

POCU/PACU Staffing Guidelines

Purpose: An appropriate number of professional nursing staff with demonstrated competence is available to meet the individual needs of patients and families in each level of perianesthesia care based on patient acuity, census, and physical facility. Staffing patterns reflect an adequate number of professional nursing staff with appropriate competencies to provide safe, quality nursing care.

1. Staff functions within written job performance descriptions and receive regularly scheduled performance appraisals.
2. Staffing is based on patient acuity, census, patient flow processes, and physical facility.
3. A competent perianesthesia professional nurse is with the patient receiving care at all times to provide direct care and/or supervision.
4. Perianesthesia assessment is performed by an RN competent in perianerthesia nursing.
5. Two registered nurses, one of whom is an RN competent in Phase I perianesthesia nursing and one nurse may be a surgery trained RN (validated with ACLS certification).
6. Staffing patterns will reflect ASPAN's Patient Classification /Recommended Staffing guidelines

POCU/PACU hours are:

Monday – Friday 0600 – 2230

Saturday & Sunday 0600 – 1800

All other hours are covered by "On Call" staffing

Community Hospital East

Call Policy

The call policy outlines the sequence of events to cover the POCU/PACU area when the department is closed (for emergency cases). All RN's will participate in the call rotation, after orientation is completed. Weekend Option Position and the PRN position is the exception to the rule, (W/O position only participates in the holiday call schedule & the PRN position can elect to pick up call hours after completing orientation at least 6 months of working in the department.

It is each staff member's responsible to be available for his or her assigned call period. Beepers are provided or you can use your personal cellphone, if you are not at home. You should be available to reach the hospital within 30 minutes of receiving a call. Call hour's starts at the end of the last scheduled RN shift. (For example: if the last nurse gets off at 2130, then your call time starts at 2100.

Weekday Call, generally starts at 2200 and ends at 0600, one RN is "on call" Sunday night through Thursday night- Friday night is covered by a 1st and 2nd RN

Weekend Coverage includes a weekend option nurse working 6am to 6pm, every Saturday and Sunday.

Weekend Call: Saturday- 1st 0600 to 1800 Sunday 1st 0600 to 1800

1st 1800 to 0600 1st 1800 to 0600

2nd 1800 to 0600

Holidays are covered with 2RN's covering 24 hours.

Everyone must sign up for his or her own call time, all days must be covered.

Failure to arrive on time will be reported to the Team Leader and result in a minor disciplinary action being placed in your file. 3 minors equal a major, and 3 majors equal loss of job.

All nurses need to sign up for a least 2- 3 weekdays and a weekend. Holiday call is assigned at the beginning of the year by the Team Leader and the holidays are rotated each year.

Everyone needs to take an equal share of Monday and Friday's and your weekend and the days before and after a holiday.

June 2014/CHE PACU Call Schedule

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1 (on May)	2 Jess	3 Tricia	4 Jacquie	5 Jess 12-6 Jacquie 9-12	6 1st Jess 2nd Terri	7 1st Tricia 1st Terri 2nd Jess
8 1st Tricia 1st Terri	9 Jacquie	10 Jess	11 Angela	12 Terri	13 1st Terri 2nd Angela	14 1st Terri 1st Angela 2nd Tracey
15 1st Angela 1st Jess	16 Terri	17 Jess	18 Terri	19 Terri	20 1st Terri 2nd Jess	21 1st Terri 1st jess 2nd Terri
22 1st Terri 1st Jess	23 Terri	24 Jess	25 Jacquie	26 Jess	27 1st Terri 2nd Michelle	28 1st Terri 1st Michelle 2nd Terri
29 1st Michelle 1st Terri	30 Angela					

Community
Health Network

QUALITY/SAFETY MANAGEMENT PLAN
SURGERY SERVICES

Community Hospital North
Community Hospital South
Community hospital East
Community Hospital Anderson
The Indiana Heart Hospital

December 2005

Index

Quality/Safety Management Plan
Surgery Services
Scope of Service

I. Mission/Vision/Values Statements

Mission

The mission of Surgery Services is to be a leader in providing a full continuum of services to the community serviced by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient surgery service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized surgery options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest quality surgical care, creating an exceptional experience for physicians, patients, families and employees.

Vision

It is the objective of Surgery Services to accomplish our mission by partnering with physicians, patients, families and employees. We will benchmark performance indicators and major processes. We will creatively develop new approaches and alternative delivery systems offering state of the art technology for best demonstrated practices in surgery services. These continuous improvements will result in a system that will provide high quality services as evidenced by total customer satisfaction.

Values

Exceptional Physician Experience

We believe collaboration with physicians is the key to success. In partnership with our medical staff, we will provide the safest, most progressive surgery care available in technologically advanced facilities, while supporting physicians and their office staff with friendly, convenient and efficient service.

Exceptional Patient and Family Experience

We deliver convenient surgery care in a friendly and compassionate environment, and treat our guests with respect and courtesy every step of the way. We focus on maximizing convenience and privacy while keeping them informed and involved in all aspects of the patient's care.

Exceptional Employee Experience

We create a fulfilling, motivating and rewarding work environment that facilitates innovation, creative solutions, empowerment and pride. Our team members are responsible, accountable and treat each other as professionals and with respect.

Business Growth

We strive to continually grow our business by creating the most surgeon-oriented surgical facilities in the Midwest. We provide our patients with the strongest blend of quality, service and price, making our facilities the customer's and payor's best value for surgery care.

Financial Performance

We focus on the delivering safe and cost-effective health care through efficient use of our resources.

II. Types and ages of patients served

Surgery Services provide services tailored to the special needs based on age: infants, children, adolescents, adults, and senior adults. Interventions are provided throughout the continuum with the exception of major organ transplantation. Heart lung bypass procedures are available only at TIHH.

III. Scope and complexity of need; extent to which needs are met

Services are designed for all levels across the health continuum. Services include education and consultation from pre-procedure planning to discharge follow-up.

The continuum of care is comprehensive and includes but not limited to:

- Community Support
- Consultation
- Education
- Home Health
- Inpatient
- Outpatient
- Pre-operative Clinic
- Wellness

Unit Description

CHE	6	Surgery suites
	2	Endo suites
	6	PACU 1 Surgical beds (to include one isolation bed)
	6	Pre/Post-operative beds
CHN	8	Surgery suites
	17	Pre/Post-operative rooms
	6	PACU 1 Surgical beds
CHS	5	Surgery suites
	5	PACU 1 beds (to include one isolation bed)
CHA	6	Surgery suites
	2	Special procedure rooms
	8	PACU 1 Surgical beds (to include one isolation bed)
	18	Pre/Post-operative beds

Surgical inpatient units (pre/post procedure care)

East patient's need for nursing care is assessed by a Registered Nurse at the time of admission with a complete health assessment including physical, psychosocial, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to a surgery support tech. Reassessment of the patient's condition occurs at least every eight hours by an RN or more frequently based on changes in the patient's condition.

A care manager is designated on admission and is accountable for planning the care throughout the hospital stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations are measured through patient satisfaction surveys and appropriate referrals made as necessary.

Observation unit

This unit provides care for post-surgical/procedural patients as well as medical patients.

East patient's need for nursing care is assessed by an RN at the time of admission with a complete health assessment including physical, psychosocial, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to an LPN, Clinical Technician, or a Student Nurse Extern. Reassessment of the patient's condition occurs at least every eight hours by an RN or more frequently based on changes in the patient's condition.

The RN is accountable for planning the care throughout the observation stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations is measured through patient satisfaction surveys and appropriate referrals made as necessary

Pre-op Clinic

The pre-operative clinic offers pre-admission testing/screening and education for patients up to seven days prior to their surgical procedure. The pre-op clinic patients are seen by a hospital intensivist. Appointments are made through Surgery Scheduling at 317-355-5489 and can be scheduled from 9am – 1pm on Monday and Wednesday. Special arrangements can be made outside of this time if needed.

Surgery pre-procedure area

The Rn receives and admits the patient to the unit. The patient is initially identified using at least two patient identifiers. The RN performs an assessment on each patient who is admitted through this unit. This assessment includes the identification of the patient's physical, psychosocial, spiritual and economic needs. The RN also obtains a complete health history by utilizing advanced interview techniques, including the use of the open-ended questions to gather data. Labs, x-rays, EKG and other tests are ordered based on direction from the Surgeon, Endoscopist and /or Anesthesiologist/physician. All verbal and/or telephone orders are verified by the RN utilizing the RAV (read –back and verify) system. Pre-procedure teaching is done by the RN with the patient, and/or their family/significant other. This educational component includes, but is not limited to, the process that is utilized to ensure the patient's safety, such as repetitive questioning regarding allergies, type of procedure, and patient cart rails in place. The patient is apprised of what can be expected from the Anesthesiologist/physician such as meeting him/her pre-procedure, having an IV started (if not already in place), and the process of anesthesia sedation. The patient is also educated regarding the stay in PACU if appropriate. The RN discusses the discharge instruction sheet and reinforces those areas that are e specific to the patient and his/her procedure. Although there is a basic teaching plan in place, education is individualized to address those previously assed needs. The patient acknowledges understanding of the instruction verbally and by signing the instruction sheet. Any potential problems that are identified are addressed by the RN pre-procedure. These potential problems include but are not limited to the need for crutches or walker, no ride home, or no responsible person to stay with the patient at home.

Pre-procedure medications are administered and IV fluids are initiated by the RN as ordered by the Anesthesiologist and/or Surgeon. The RN ensures that consent for the procedure has been obtained prior to administering pre-operative medication to the patient. Any relevant information regarding a patient's special need is communicated verbally to the Operative Room RN and PACU RN utilizing the "hand-off" approach in addition to documentation of the same.

A systems approach is utilized when the Rn performs the assessment of a patient prior to a procedure. Baseline vital signs, including temperature, pulse, respiration, blood pressure measurement, and pulse oximetry are obtained. Cardiac monitoring is available as necessary. A re-assessment is performed as deemed necessary by the RN based on subjective and objective data. An RN is always in attendance/available when a patient is present in the unit.

Surgery

All patients' undergoing a surgical procedure is assigned a minimum of one circulating registered nurse and one scrubbing registered nurse or certified surgical technician. Additional circulators and scrubs are provided based upon the acuity/complexity of the procedure, physician request, and /or use of special equipment such as a laser. AORN Recommended Standards will be utilized as guidelines for safe optimal staffing and practice within the operating room setting. A Board Certified Anesthesiologist provides all anesthetics within the surgery setting. All sites provide on-site staff from 7:00am – 7:30pm Monday through Friday. Exact times for scheduled procedures vary slightly by site. Add-on cases are performed on a case-by-case basis based upon the current surgery schedule at the time of request. After hours and emergency services are provided by on-call teams.

PACU I (Surgery)

Our handoff communication process is implemented at this time. The PACU RN receives a verbal report from the Anesthesiologist and Circulator as she/he accepts responsibilities for the patient's case. The RN performs an initial assessment and documents the findings. The assessment includes, but is not limited to, patency of airway, respiratory rate and depth, blood pressure readings, patient temperature, condition and color of the skin, patient safety needs, neuromuscular status, presence and condition of drainage tubes and catheters, dressings on operative sites, location and condition of IV sites and lines, assessment and documentation of input and output, Aldretti type score, and level of emotional and physical support needed. This assessment is ongoing during the patient's PACU care. The Rn re-assesses the patient every 15 minutes during PACU care, but may perform a re-assessment more frequently if condition warrants. All RN's delivering care is ACLS certified.

A certain level of competence is required by all Rn's delivery this care, therefore each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient's classification, each patient receives care on the basis of assessment of needs. Re-assessments are performed with any change in condition, cardiac rhythm and post-invasive procedure. The data obtained is interpreted and documented by the RN. Nursing actions and/or interventions with outcomes are documented. The RN collaborates with the Anesthesiologist and/or Surgeon as appropriate. All orders are repeated and verified with the ordering physician.

The same standard of post-anesthesia care is provided to ICU patients whether in the PACU or in the ICU, based on Anesthesiologist's orders. The care is provided by ICU RN's who have been cross-trained. At CHA patients who return to ICU from OR are recovered by the PACU RN for the first hour.

When a patient has met discharge criteria, but their bed is unavailable, reassessments and vital signs will be completed every thirty minutes.

Those patients whose total care requires expertise and resources that are unavailable at CHI will be stabilized, treated, and transferred to the appropriate facilities.

PACU II (Surgery)

This area is a step-down unit from the Phase I unit. Patients are taken to this unit to recover prior to discharge. Patients who have only received local or IV sedation are generally taken here directly from the procedure room. Families are able to join the patients during this phase of their care. Discharge instructions are reinforced with patient and family by the RN and a written copy is sent home with the patient.

A complete assessment utilizing a systems approach is performed by the RN on each patient upon admission to PACU II and prior to discharge. Reassessments are done as necessary with any change in condition or previously assessed parameters. Cardiac monitoring and pulse oximetry capabilities are available if necessary. If a patient's condition warrants, he/she will be transferred to PACU I.

Extended Recovery Unit (CHE/CHA only)

The patient's condition and vital signs will be assessed at least hourly or more frequently as ordered or deemed necessary. Outpatients who have had a surgical or other invasive type procedure requiring extended recovery care will be placed on this unit. A typical length of stay in this unit is 6 – 8 hours. Patients requiring overnight 23 hour stays or longer will receive their care on the observation unit or inpatient surgical unit.

Post-discharge instruction will be reinforced with the patient and family by the RN prior to discharge.

Home Care

- Involved with continuum of pathway
- Referred to appropriate home care specialist
- Involve hospital Social Services as necessary
- Special needs are met by referral to specialty personnel, i.e., ostomyy care and education, physical therapy for crutch and/or walker training

IV. Appropriateness, clinical necessity and timeliness of support services provided directly by the organization or through referral contacts

Surgical services are provided by a multi-disciplinary professional staff which includes but not limited to: Primary Care physicians, Surgeons, Anesthesiologist, Nurses, Certified Surgical Technologists and internal and external case managers. Ancillary Surgical Services staff includes: Student Nurse Externs, Certified Surgical Technologist Students and Volunteers. In addition, clinical support is provided by: Respiratory Care, Pharmacy, Radiology, Laboratory, Nutrition, Physical Therapy, Social and General Services, Materials Management, Finance and Information Systems as needed in a timely manner.

The administrative staff for Surgical Services includes: the Executive Director, Co-Medical Directors, Team Leaders, A Financial Consultant and a Human Resource representative. In collaboration with Team Leaders, direction and coordination of clinical services is provided by Clinical Facilitators of operations, education and practice.

V. Availability of necessary staff

Surgical Inpatient Unit (pre and post procedure care)

Care delivery is provided using a Care Team Model and the master staffing plan. Nursing staff members are assigned patient care by a designated resource nurse or Clinical Facilitator. Assignments are based on the following elements:

- Continuity of nursing staff assigned
- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff
- Consideration of relevant Infection Control and Safety issues

To ensure availability of adequate staff the following mechanisms are in place:

- Twenty four hour leadership accountability
- Centralized Scheduling
- Human Resources
- Network Float policies

Observation Unit

Care delivery is provided using the master staffing plan. Assignments are based on the following elements:

- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff
- Consideration of relevant Infection Control and Safety issues

To ensure availability of adequate staff the following mechanisms are in place:

- Centralized Scheduling
- Human Resources
- Network Float policies

Surgery pre-procedure area

A modified Primary Nursing model for delivery of care is utilized in the pre-procedure care unit. The RN's are cross-trained to work in the admission, procedure and recovery areas. All are required to maintain a level of competence. The RN is competent to admit, assess and administer care to a pre-procedure patient of any level of acuity or complexity. The LPN is required to maintain competency to administer care to a pre-procedure patient of any level of acuity or complexity under the direction of an RN. If the patient's identified needs require more nursing resources and additional Rn is utilized to assist. Support personnel are available to assist the RN. This unit is routinely staffed by RN's Monday through Friday at:

- CHE 6:00am – 5:00pm
- CHN 5:00am – 9:30pm
- CHS 6:00am – 8:30pm
- CHA 7:00am – 5:00pm

Surgery

All procedures are assigned a minimum of one monitoring/circulating RN employed by the Community Hospital Indianapolis. Demands of each procedure room schedule will be optimally matched with the skills and expertise of assigned competent staff. Assignment of additional personnel will be provided as necessary with consideration to:

- Need for hospital scrub: RN or CST
- Acuity/complexity or procedure
- Physician request
- Special equipment, i.e., laser

One CHI credentialed laser nurse will be assigned to each laser procedure with exclusive responsibility to laser operations the exception being laser ophthalmic procedures. General anesthesia services are provided by Anesthesiologists. The surgical area is open for routine procedures from 7:00am – 7:30pm Monday through Friday, at CHA 7:30am – 6:00pm. Outside of normal working hours emergency coverage is provided by on-call teams.

PACU I (Surgery)

PACU I utilizes a modified Primary Nursing model for delivery of care. With this model an RN takes primary responsibilities for assessing and addressing a specific patient's needs during his/her stay in the PACU I. PACU Team Leader coordinates care and activities. Primary care is delivered by an RN. All PACU RN's are ACLS certified with re-certification completed biannually

A certain level of competence is required by all RNs in the PACU, therefore, each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient classification, each patient receives care on the basis of assessment of needs. Clinical technicians assist with designated duties under the directions of the RN. This unit is routinely staff Monday through Friday at:

- CHE, 7:00 a.m. – 10:30 p.m.
- CHN, 5:00 a.m. – 9:30 p.m.
- CHS, this unit closes at 8:30 p.m.
- CHA, 7:00 a.m. – 6:00 p.m.

Outside of working hours care is provided by on-call teams.

PACU II (Surgery)

- PACU II utilizes a modified Primary Nursing model that also represent the care delivery system in PACU I. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Assignment of care is based individually on the assessed patient needs. The unit is routinely staffed for surgery 8:00 a.m. – 11:30 p.m., Monday through Friday at CHE and CHN. Hours of operation at CHS for surgery are 6:00 a.m. – 8:30 p.m. Monday through Friday. Hours of operation at CHE and CHN are 7:00 a.m. – 5:30 p.m. Monday through Friday. At CHA hours of operation are 6:00 a.m. – 10:00 p.m. Outside of normal working hours care is provided by on-call teams.

Extended Recovery Center (CHE only)

Care is provided utilizing a team approach. This team is comprised of RNs and Clinical Technicians. Staffing is a 1:3 ratio. Assignments are based on the following elements:

- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff
- Consideration of relevant Infection Control and Safety issues

To ensure availability of adequate staff the following mechanisms are in place:

- Centralized scheduling
- Human Resources
- Network Float policy

This unit is staffed Monday through Friday 7:00 a.m. – 11:00 p.m.

VI. Standards/Guidelines for Surgery Services Practice

Standards and Guidelines for Practice are utilized to provide care and include but are not limited to the following:

- Patient Care Pathways
- Professional Practice Model
- Patient Rights Handbook
- Advanced Practice Committee Guidelines/Recommendations
- Unit based guidelines for patient care that include:
  - ASPAN
  - AORN
  - SGNA
- Hospital Policy and Procedures
- External Regulatory Standards

VII. Methods to assess and meet patient needs

- Nursing process
- Admission assessment forms
- Risk screens/pre-admission clinic
- Pathway implementation
- Patient satisfaction surveys
- Follow-up phone calls
- Cost comparisons
- LOS comparisons
- Outpatient admission rates
- Review scope of care (III and IV)

VIII. Identification of MAJOR internal and MAJOR external customers

Internal

- Employees
- Physicians

External

- Payers/employers
- Patients/significant others
- Community

IX. Patient/significant other education

Teaching protocol

This education will be age specific to include the following:

- Patient rights and responsibilities
- Estimated or schedule time for surgery/procedure
- Monitors to be utilized patient identification protocol
- Anesthesia related teaching by appropriate professionals, i.e., Registered Nurse, Anesthesiologist
- Explanation of perioperative environment and safety procedures
- Post procedure destination
- Usual recovery time with exceptions and patient/family participation expectations
- Time and location family/significant other may resume visitation
- Assurance that needs will be met, i.e., warm blankets, pain relief and antiemetic therapy.
- Possibility of O_2 therapy per their need
- Instruction of pain scale 0 – 5
- Validation of understanding patient/family/significant other of education with documentation
- All other educational needs will be individualized as needed per specific procedure, i.e., SCDs, PCAs, crutch training and drains
- All education is reinforced to patient, family and significant other prior to discharge and documented on appropriate form per unit protocol

See Scope of Care (III and IV for individualized unit patient education

Education tools

- Videos
- Pathways
- Tours
- Handouts

Home Care

- Education built into pathway

Surgical Services patient follow-up

- Outpatient procedures will receive a follow-up phone call within 24 – 48 hours. This will give the patient customer opportunity to voice questions, allow reinforcement of physician direction and identify satisfactions as well as opportunities for improvement
- A letter will be sent to those outpatients who are not reached 24 – 48 hours post procedure by phone after 2 attempts
- Opportunities for improvement are specifically identified through patient satisfaction questionnaires

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/2013

NPP#: ORSPP: P-02
Page 1 of 2
EFFECTIVE: 6/13/13

TITLE: **Pre-operative PROTOCOLS FOR THE REGISTERED NURSE**

Performed by: RN Caring for patient scheduled for an Operative Procedure

Purpose: To provide pre-operative care direction via protocols for the Registered Nurse (RN) providing Care to the patient scheduled for an operative procedure

Policy Statements:
1. The protocols listed in this policy are specific to OPERATIVE procedures and may be initiated by the RN prior to a scheduled procedure. THESE PROTOCOLS DO NOT APPLY TO ANY PATIENT OUTSIDE OF THE OPERATIVE/SURGICAL AREA.
2. Each protocol requires a medical order to initiate the pre-operative protocol. The protocol selected will be the protocol that matches the type of procedure scheduled. The RN may delegate specific tasks from the protocol to other staff within their scope of practice.
3. RN's working in the preoperative area of care must complete competency verification on the process of initiating and implementing pre-operative protocols.
4. If a patient is scheduled for a procedure and the procedure is included in one of the attached lists, then the RN will initiate that pre-operative protocol for that specific procedure. (SEE ATTACHED LISTING OF PROTOCOLS). If pre-operative protocol is not on the list of approved protocols then the RN must contact the surgeon to have him/her enter Pre-operative orders.
5. Pre-operative protocol orders will be initiated for all patients unless there are specific orders from the physician to not initiate the protocol order set. See listing of pre-operative protocols.
6. The RN must verify patient allergies prior to administering any medication.

General Information:
1. All orders entered for the pre-operative patient by protocol must be later cosigned by the procedural physician.
2. Additional information pertaining to specific procedures may be obtained from those specific procedure policies.

Equipment:
1. Order entry through Care Connect (select order entry, go to order set and select appropriate pre-operative protocol that matches the surgical procedure) and select ordered "as per protocol".

Procedure:
1. Initiate appropriate protocol based on the specific procedure that is scheduled.
2. Place the pre-operative orders by the using the approved associated operative protocol, on behalf of the procedural physician, who will later cosign these orders. The "Per Protocol" mode will be used for placement of these orders.
3. Monitor patient based on the protocol initiated, response to the protocol, and other physician orders.

Documentation Guidelines:
Document in Care Connect for Order Entry
Document Assessment on patient designated flow sheets within Care Connect
Document all medications on the electronic MAR

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/2013

NPP#: ORSPP: P-02
Page 2 of 2
EFFECTIVE: 6/13/13

Approved:	Dr. Michael Venturini	
Approved by:	Amy Glover Vice President Surgery and Surgery Services	Date: 3/14/13
Approved by:	Risk Management	Date: 4/10/13
	Infection Prevention:	Date: 4/10/13
Approved:	NPP Steering Committee	Date: 4/10/13

Community Hospital East

POCU/PACU Staffing

Dorine Lewis RN, CAPA	ACLS
Jacque Burkholder RN	ACLS, PALS
Angela Gonzalez RN	ACLS
Jessica Guinn RN	ACLS, NIHSS
Erin Michael-Johnson RN	ACLS , CPR & ACLS Instructor
Michelle Jones RN, CCRN	ACLS
Kelley, Tracey RN,ARRT	ACLS, PALS
Kellie McDonough RN,CCRN	ACLS
Terri Orndorff RN	ACLS
Jerri Smoot RN	ACLS
Tricia Tolliver RN	ACLS

PRN Staffing

Kathryn Freeman RN	ACLS

ACLS is required for a for all POCU/PACU RN staff

CHE Equipment List

Updated June 10, 2014

Pre-op:

Acu-check machine	1
Acu-check docking station	1
Bed table	10
Bed side commode	1
Blanket warmer	1
Contact precaution cart	1
Computer on wheels	4
Computer-wall mounted	4
Crash cart-adult	1
Defibrillator	1
Desk top computer	6
EKG Machine	1
Fax/copier machine	1
IV pole on wheels	1
Ice machine	1
I-stat machine	1
I-stat printer	1
I-stat docking station	1
I-stat cart	1
Label printer	1
Monitor-Dash 4000	9
Monitor-Solar	1
Medication refrigerator	2
Oxygen flow meter	10
Printer	2
Pyxis med station	1
Portable suction	1
Scale	1
Suction-wall unit	10
Thermometer-tympanic	4
Thermometer-temporal	0
Thermometer-oral	1
TV with dvd player	1

CHE Equipment List

Updated June 10, 2014

PACU

Acu-check machine	1
Acu-check docking station	1
Alaris Pump	1
Alaris channel	2
Art-line blocks	8
Art/CL/CT supply cart	1
Bair Hugger	4
Bed table	2
Blanket warmer	1
Contact precaution cart	1
Computer on wheels	5
Crash Cart-adult	1
Crash Cart-peds	1
Defibrillator	1
Desk top computer	2
Freezer	1
Fax/copier machine	1
IV pole on wheels	11
Ice machine	1
I-stat printer	1
Label printer	1
Monitor-solar	6
Medication refrigerator	1
Oxygen flow meter	14
Oxygen Y-splitter	5
Oxygen tanks	5
Printer	1
Patient supply carts	5
Pyxis med station	1
Portable monitor	1
Portable suction	1
Portable IV poles	6
Scale	1
Suction-wall unit	10
Telemetry printer	1
Thermometer-tympanic	3
Thermometer-temporal	1
Ventilator	1

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 18

RELATIONSHIP WITH IOPO

"18. **Relationship with an organ procurement organization**: There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 18 are met with a copy of the Community Hospital East Organ Donation policy. There is a copy of the current contract with the Indiana Organ Procurement Organization, Inc. (IOPO)

IOPO

INDIANA ORGAN PROCUREMENT ORGANIZATION

June 11, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Dr. VanNess,

I would like to express our sincere appreciation for the collaborative partnership with Community Hospital East in regards to the lifesaving gift of organ, tissue and eye donation.

The professionalism and enthusiasm of the Community Hospital East staff and physicians has ensured the spirit of the donation process is promoted throughout the hospital and beyond. IOPO has found Community Hospital East to be a robust advocate and partner who has consistently worked to foster a compliant and innovative approach to donation.

We thank Community's Leadership and staff for their continued support and dedication to organ and tissue donation. If you have any further questions please feel free to reach out to me directly.

Warm Regards,

Steve Johnson
Chief Operating Officer
C –

TITLE: ORGAN AND TISSUE DONATION

Purpose:

1. To provide guidelines for health care providers for the process of organ/tissue donation and compliance with Indiana's Uniform Anatomical Gift Act IC 29-2-16-02

Policy Statements:

1. Community Hospitals are affiliated with Indiana Organ Procurement Organization (IOPO) for organ, eye and tissue donation. **All calls are to be made to the Indiana Donor Alliance (IDA), the telephone service for IOPO.** The toll free number is
2. No mechanical support should be withdrawn from the dying patient prior to the referral call to IDA and determination of medical suitability from IOPO.
3. The option of organ or tissue donation is to be offered to families by an IOPO representative to ensure the greatest sensitivity to matters such as timing, the circumstances of the patient's death and the beliefs and desires of those families.
4. Indiana's Uniform Anatomical Gift Act IC 29-2-16-02 provides means for a written, verifiable legal declaration of a patient's intent to donate anatomical gifts upon death. Any next of kin or guardian may not, under the law, supersede a patient's decision. Without a verifiable declaration, IOPO will follow the standard protocol of seeking family consent by offering the option of donation to the next of kin.
5. The monthly audit conducted by IOPO to identify areas of potential non-compliance will be forwarded to CHNw individuals and teams for review and action and made available to regulatory and accrediting bodies.

General Information:

Definitions:

1. Death: Individual who has sustained an irreversible cessation of all circulatory and respiratory function.
   All deaths include:
   - All cardiac deaths
   - All imminent deaths or patients who meet clinical triggers as measured by:
     - GCS of 5 or less
     - At first mention of withdraw of care
   - All still born births (where a death certificate is required)
   - DOA's (Dead on Arrival)
2. Brain Death: a sustained irreversible cessation of all functions of the entire brain, including the brain stem.
3. Imminent Death: Individual who has a condition from which a reasonable degree of medical certainty, there can be no recovery and that death will occur within a short period of time without instituting life-prolonging procedures. A patient who meets clinical triggers for organ donation.
4. Reportable Death: Deaths requiring a death certificate or fetal death certificate as required by Indiana State Department of Health. No reporting is required for abortions, miscarriages or fetal deaths less than 20 weeks gestation.
5. Organ Donation: Donation of solid organs which includes heart, lungs, liver, kidneys, pancreas and small intestines from an individual who is brain dead or meets criteria for donation after cardiac death.
6. Tissue Donation: donation of tissues, which includes heart valves, veins, arteries, tendons, ligaments, bone, fascia, skin corneas and whole eyes from an individual whose heart is no longer beating.

The hospital recognizes the importance of allowing those who wish to donate the opportunity, in the hope that solace may be provided to the grieving family by their decision to participate in improving the quality of life for others. CHNw wishes to facilitate the donation of organs, tissue and eyes in the board interest of society and those awaiting transplantation, without infringing upon a family's deeply held beliefs, values and rights.

IOPO provides information to the family of each potential organ or tissue donor regarding the desire of the patient for organ or tissue donation as designated on his/her Bureau of Motor Vehicles license or registration through www.donatelifeindiana.org. If the patient has not designated donation on his/her Bureau of Motor Vehicles license, the family has the option to donate or decline to donate organs or tissues. There will be no cost to the family of donors once the decision has been made to donate anatomical gifts.

To facilitate the opportunity for anatomical gift donation, the following processes involved with this procedure are identified:

1. CRITERIA for donation: See IOPO Manuals
2. CROSS REFERENCE:
   - Death — NPP: R-009 "Care of the Patient After Death"
   - Autopsies: See also attached Flow Chart
   - Cardiac Death — CORP#: CLN-2054
   - Patient Rights Handbook — CLN-3035, Donation organ -- after cardiac death

Procedure:

See attached flowchart

Owned by: Organ Donor Team

Approved by:

Organ Donor Team	12/2011
Risk Management	12/2011
Infection Prevention	12/2011
Chief Nursing Officer Designee	12/26/11

Approved: _____ Date:

Chief Executive Officer CHI/Chief Operations Officer CHNw

INTRODUCTION: ORGAN DONATION

Patients have the right to be organ or tissue donors upon their deaths, if they meet donor criteria. Indiana State Law and the Anatomical Gift Act require hospitals to offer the option of organ and tissue donation to all potential donors and/or families. In 1998 the Centers for Medicare and Medicaid, CMS required all health care organizations receiving Medicare reimbursement to call the local donor alliance organization for every anticipated and actual patient death. In Indiana, the donor alliance is the Indiana Donor Alliance, IDA confers with donor organizations to determine donor suitability and next steps.

Within the Community Health Network, staff members contact the IDA, who confers with out donor partners. For Community Hospital North, East, South and TIHH donor services are provided by the Indiana Organ Procurement Organization (IOPO). Community Anderson partners with Indiana Organ Procurement Organization (IOPO), Community Tissue Services (CTS) and Lions Eye Bank (LEB). The attached flowchart guides the caregiver through the process. Below are listed resources and experts.

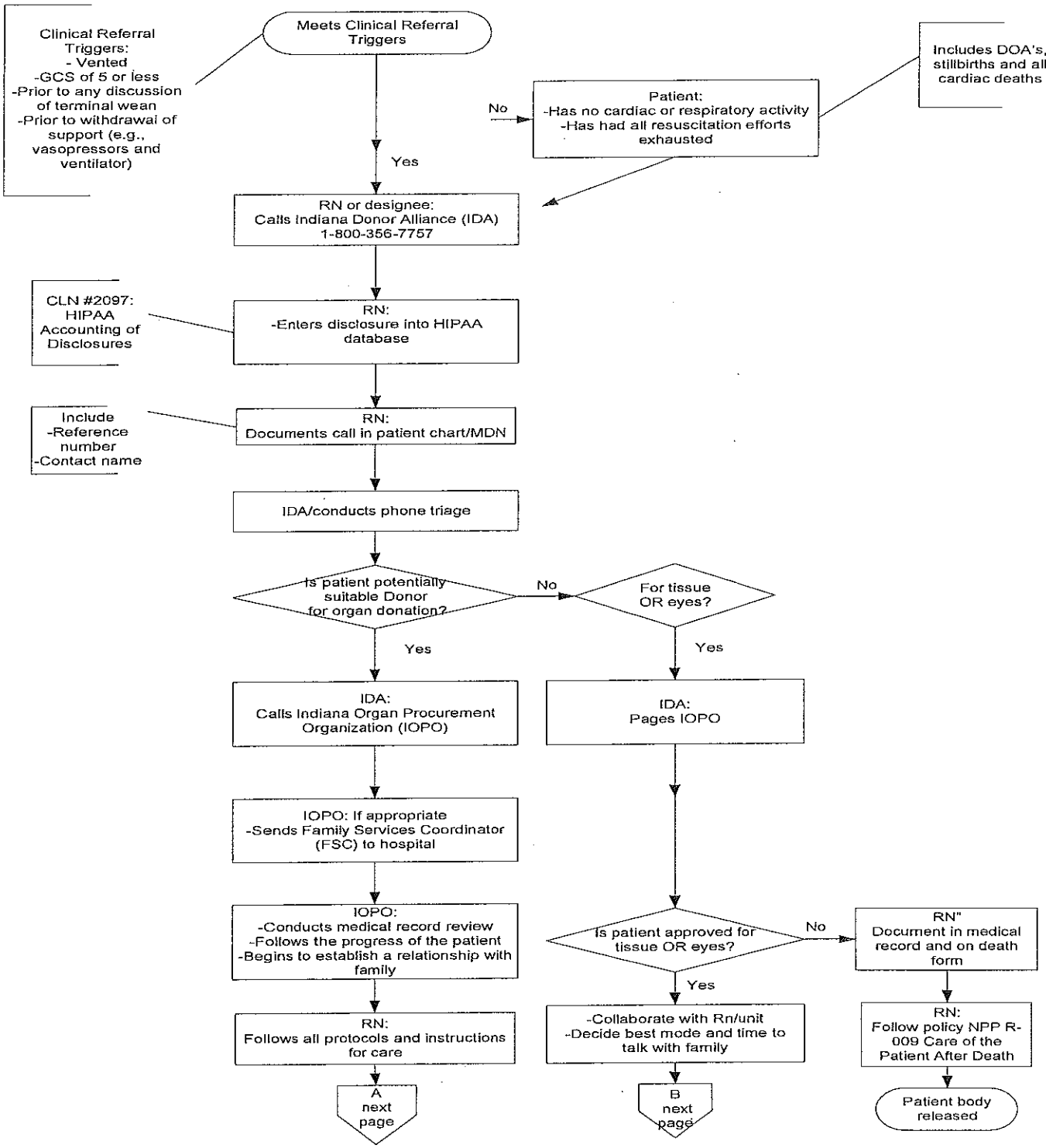
Indianapolis

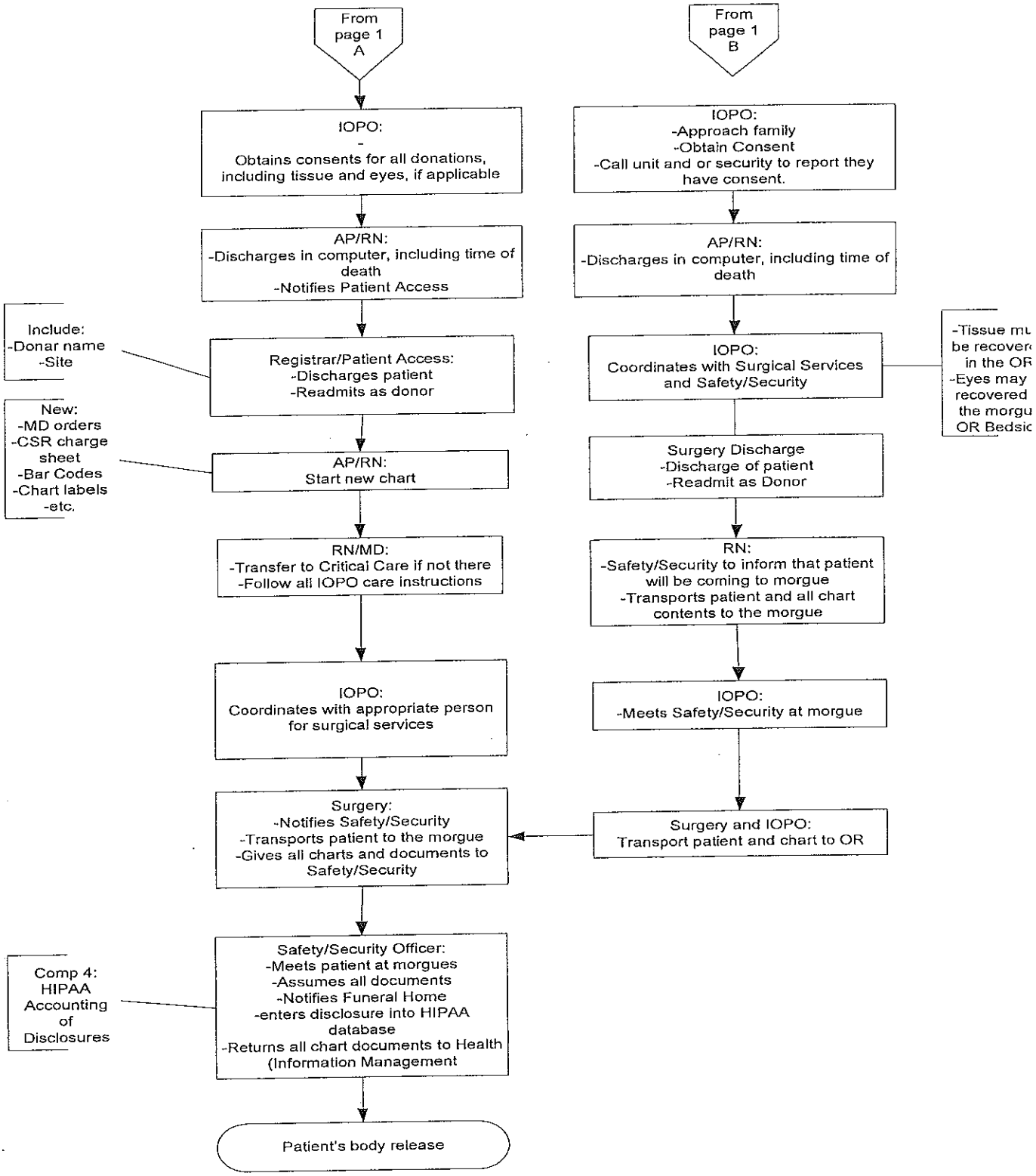
Experts/Resources
Network Donor Council Leader
Chaplains CHE CHN CHS
Ethics Committees (Call Medical Staff Office) CHE/N CHS
Indiana Donor Alliance (IDA)
Indiana Organ Procurement Organization (IOPO)
Corporate Clinical Policy (CLN) 2055 "Organ & Tissue Donation"
Nursing Policy/Procedure (NPP) R-09 "Care of the Patient After Death"
Donation After Cardiac Death (Organ) CLN-3035

Anderson

Experts/Resources
Nursing Administration Pager
Indiana Donor Alliance (IDA)
Indiana Organ Procurement Organization (IOPO) iopo.org
Community Tisssue Services (CTS) communitytissue.org
Lions Eye Bank (LEB) lionseyebank.org
Hospital Policy H8 "Anatomical Gift Donation"

Organ & Tissue Donation




From page 1 A
From page 1 B
IOPO:
-
Obtains consents for all donations, including tissue and eyes, if applicable
IOPO:
-Approach family
-Obtain Consent
-Call unit and or security to report they have consent.
AP/RN:
-Discharges in computer, including time of death
-Notifies Patient Access
AP/RN:
-Discharges in computer, including time of death
Include:
-Donar name
-Site
Registrar/Patient Access:
-Discharges patient
-Readmits as donor
IOPO:
Coordinates with Surgical Services and Safety/Security
-Tissue mu
be recover
in the OR
-Eyes may
recovered
the morgu
OR Bedsic
New:
-MD orders
-CSR charge sheet
-Bar Codes
-Chart labels
-etc.
AP/RN:
Start new chart
Surgery Discharge
-Discharge of patient
-Readmit as Donor
RN/MD:
-Transfer to Critical Care if not there
-Follow all IOPO care instructions
RN:
-Safety/Security to inform that patient will be coming to morgue
-Transports patient and all chart contents to the morgue
IOPO:
Coordinates with appropriate person for surgical services
IOPO:
-Meets Safety/Security at morgue
Surgery:
-Notifies Safety/Security
-Transports patient to the morgue
-Gives all charts and documents to Safety/Security
Surgery and IOPO:
Transport patient and chart to OR
Comp 4:
HIPAA Accounting of Disclosures
Safety/Security Officer:
-Meets patient at morgues
-Assumes all documents
-Notifies Funeral Home
-enters disclosure into HIPAA database
-Returns all chart documents to Health (Information Management
Patient's body release

TITLE: DETERMINATION AND DOCUMENTATION OF BRAIN DEATH AND TERMINATION OF THEAPEUTIC MEASURES UPON DETERMINATION OF BRAIN DEATH

Purpose:
To provide for a uniform process for the determination and documentation of brain death, and to provide guidance for clinicians when caring for a patient who has been determined to be brain dead.

Definition of Brain Death: Indiana law defines brain death as follows: Brain death has occurred when an individual has sustained irreversible cessation of all functions of the entire brain, including the brain stem. A determination of death must be made in accordance with accepted medical standards.

Determination of Brain Death: Accepted medical standards for the determination of brain death have been published in the medical literature. The diagnosis of brain death shall be made by a physician licensed to practice in the State of Indiana and currently on the Medical Staff of Community Hospitals. The following process for the diagnosis and certification of brain death shall be used at Community Hospitals of Indiana.

A. A physician must make the determination of an irreversible well-defined etiology of unconsciousness and document this diagnosis on the *Determination and Documentation of Brain D*eath form (attached).
B. Conditions which can mimic brain death (e.g. hypothermia, hypotension, and drug or substance intoxication) must be excluded and this documented on the Determination and Documentation of Brain Death form (attached).
C. Brain Death is a clinical diagnosis. A repeat examination is **not necessary** and the interval is arbitrary but a 6 hour period is reasonable. These examinations must demonstrate the following:
    1. No clinical evidence of cerebral function
        A) No spontaneous movement, eye opening, or movement or response after auditory, or visual stimulae or commands.
        B) No movement elicited by painful stimuli to the face and trunk (e.g., sternal rub, pinching of a nipple or finger nail bed), other than spinal cord reflex movements.
    2. No clinical evidence of brain stem function
        A) No pupillary reflex: pupils are fixed and mid position; no change of pupil size in either eye after shining a strong light source in each eye sequentially in a dark room.
        B) No corneal reflex: no eyelid movements after touching the cornea (not the conjunctiva) with a sterile cotton swab or tissue.
        C) No gag reflex: no retching or movement of the uvula after touching the back of the pharynx with a tongue depressor or after moving the endotracheal tube
        D) No cough reflex: no coughing with deep tracheal irrigation and suctioning
        E) No oculocephalic reflex (doll's eyes reflex): no eye movement in response to brisk turning of the head from side to side with the head of the supine patient elevated 30 degrees
        F) No oculovestibular reflex (caloric reflex): no eye movements within 3 minutes after removing earwax and irrigating each tympanic membrane (if intact) sequentially with 50 ml of ice water for 30-45 seconds, while the head of the supine patient is elevated 30 degrees.
        G) No integrated motor response to pain: no localizing or withdrawal response, no extensor or flexor posturing
        H) No respiratory efforts on apnea testing [$PaCO_2 > 60$ mm Hg]: the patient is oxygenated with an F_1O_2 of 100% for 10-15 minutes, preferably with an arterial line in place for rapid blood gas measurements, while adjusting ventilatory rate and volume such that the $PaCO_2$ reaches ~40-45 mm Hg. After a baseline artrial blood gas is obtained, and the patient is disconnected from the ventilator, O_2 at 6-8 L/min is delivered through a T-piece connected to the endotracheal tube or a cannula advanced 20-30 cm. into the endotracheal tube. Continuous pulse oximetry is used for early detection of desaturation, which does not usually occur when using this protocol. In most cases, a $PaCo_2 > 60$ mm Hg is achieved within 3-5 minutes after withdrawal of ventilatory support; at this point an arterial blood gas sample should be obtained and the patient should be reconnected to the ventilator (or earlier, should hemodynamic instability, desaturation, or spontaneous breathing movements

occur). If there is no evidence of spontaneous respiration before reinstitution of mechanical ventilation in the presence of a PaCo2 of > 60 mm Hg, the criteria for a positive apnea test are met.

D. Confirmtory tests should be used if the observation period needs to be shortened (e.g., unstable donors), in equivocal situations, or if one of the potential pitfalls (see Table 1 – below) cannot be ruled out. Confirmatory tests are the demonstration of the absence of intracranial circulation by angiographic contrast or radioisotopic flow studies or the demonstration of electrocerebral silence documented by an electroencephalogram. The American Academy of Neurology has stated that special confirmitory tests are not necessary to diagnose brain death in the vast majority of cases.

Table 1.
Pitfalls in Clinical Brain Death Testing

1. Hypotension, Shock
2. Hypothermia
3. Intoxication or drug overdose
4. Neuromuscular and sedative drugs, which can interfere with elucidation of motor responses
5. Pupillary fixation, which may be caused by anti-cholinergic drugs, (e.g. atropine given during a cardiac arrest), neuromuscular blocking agents, or preexisting disease
6. Corneal reflexes absent due to overlooked contact lenses
7. Oculovestibular reflexes diminished, or abolished after prior use of toxic drugs (e.g. aminoglycosides, loop diuretics, vancomycin), or agents with suppressive side effects on the vestibular system (e.g. tricyclic antidepressants, anticonvulsants, barbiturates), or due to preexisting disease.

E. Declaration of brain death should not be made less than 24 hours following the causative insult or event without a confirmatory test.

Many physiologic phenomenon can be seen in brain dead patients and may be mistaken for brain function. Many of these are likely release phenomena of the spinal cord including the upper cervical cord. Following are some clinical observations that are compatible with brain death and should not be misinterpreted as brain function:

- Spinal reflexes, such as deep tendon reflexes and triple flexion responses:
- Shivering, goose bumps, sweating, blushing or tachycardia;
- Respiratory-like movements (shoulder elevation and adduction, back arching, intercostal expansion without significant tidal volumes) are possible after brain death;
- Arm movements, such as reaching of the hands toward the neck;
- Maintenance of normal blood pressure without pharmacological support;
- Superficial abdominal reflexes;
- Babinski reflex

PROCEDURE TO BE FOLLOWED UPON DETERMINATION OF BRAIN DEATH

A. The physician documents brain death via the Determination and Documentation of Brain Death form (attached) immediately upon determination of brain death.
B. The physician shall then complete a death certificate, using as the date and time of death the date and time when brain death was documented.
C. Inform available family members that the patient has died.
D. Organ donation should be discussed with the family pursuant to Organ and Tissue Donation Policy, CLN-2055, after the clinical diagnosis of brain death has been made, and after there has been a

clinical determination that the patient is eligible for organ donation. If organ procurements authorized, proceed to follow the Organ and Tissue Donation Policy referenced above.

E. If family refuses the harvest of organs, cease all supportive therapy and mechanical ventilation and proceed pursuant to the RHC Policy, NPP#: R-009.
   1. Family members should be allowed a reasonable time to gather and inform those not currently present at the hospital or within close proximity;
   2. However, all therapeutic measures shall be removed from the body as soon as possible, not to exceed a twenty-four (24) hours period, except where necessary in the case of organ harvesting.

References:

Uniform Determination of Death act; Burn's Annoted Indiana Code; 1-1-4-3 et seq

Rippe JM, Irwin RS, Fink MP, Cerra FB [ed]; Intensive Care Medicine; 3rd Ed; Boston; Little, Brown and Co.; 1996; pp 2099-2106.

Shoemaker WC [ed]; Textbook of Critical Care; 3rd Ed; Philadelphia, W.B. Saunders Co.; 1995; pp. 1579-1583.

Evidence-based guideline update: Determining brain death in adults: Report of the Quality Standards subcommittee of the American Academy of Neurology. Eelco F.M. Wijdicks, Panayiotis N. Varelas, Gary S. Gronseth and David M. Greer. Neurology 2010; 74; 1911-1918. DOI: 10.1212/WNL.ob013e3181e242a8

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Phyllis Garrison, JD

Approved by: Professional Practice Consultant

Approved: Critical Care Committee/South — Date: 5/2011
Critical Care Committee — Date: 7/2011
Med Exec Committee

Approved by: _____
Chief Executive Officer CHI/Chief Operations Officer CHNw

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE CLN: 3035
Approved for: [X] CHE [X] CHN [X] CHS [X] CHVH Page 1 of 5
CANCELS: 8/1/12 EFFECTIVE: 3/26/14

TITLE: DONATION (ORGAN) AFTER CIRCULATORY DEATH

Purpose:
1. To provide the option of organ donation to patients' families who have made the decision to withdraw medical treatment/support.
2. To provide guidelines and processes to facilitate this type of organ donation, known as donation after circulatory death (DCD) or controlled non-heart beating donation.

Policy Statements
1. This policy applies to all personnel involved in the process of retrieving organs from a DCD donor.
2. A multidisciplinary team approach will be utilized to provide appropriate support for the donor family.
3. If a request is made by the family to be present at the time of death, every attempt will be made to facilitate this request
4. The family will be offered the opportunity to be with their loved one after the organ recovery surgery.
5. A DCD donation is a terminal ventilator weaning process, to be managed and guided by the end of life protocol.

General Information:
1. To date, the great majority of organ donors have been persons declared dead by brain death criteria. However, before brain death criteria were established, it was a common practice to donate organs from persons who were declared dead due to cardiac and respiratory criteria.
2. The employee may also refer to corporate clinical policy CLN#: 2055, *Organ and Tissue Donation* and nursing policy/procedure NPP#: R-9, *Care of the Patient After Death.*
3. Definitions:
   a. **Donation after circulatory death (DCD)**: organ recovery from a patient pronounced dead on the basis of irreversible cessation of circulatory and respiratory function.
   b. **Non-heart beating donor**: a patient pronounced dead on the basis of irreversible cessation of circulatory and respiratory function
   c. **IOPO**: Indiana Organ Procurement Organization
   Designated requestor: Determined to be the best person to approach the family/obtain organ donation consent, based on a team huddle among the IOPO coordinator and appropriate hospital staff.

   The selection criteria for a DCD donor shall be limited to a patient:
   a. Who sustained an irreversible, severe, illness or injury no hope for survival or meaningful functional status but who does not meet brain death criteria, *and*
   b. Whose family, in consultation with the attending physician, has made the decision to withdraw medical treatment/support. This discussion and outcome are documented in the patient's hospital medical record, *and*
   c. Who is being maintained on artificial ventilation and is not expected to maintain a sustainable respiratory effort without mechanical support, *and*
   d. Whose cardiopulmonary death, in the opinion of the responsible physician, will likely occur within 60 minutes following withdrawal of hemodynamic and respiratory support, *and*
   e. Whose cause of death is known.

Equipment: None

Procedure:
   a. **Donation Discussion**: the discussion about the option of donation will take place only after the decision to remove medical treatment/support has been made. The decision to withdraw medical treatment/support must be made independently of, separately from, and predating any discussion about DCD/non-heart beating organ donation.

b. **Referral**: A referral to the Indiana Donor Alliance is to be made when it is determined that death is imminent, the Glascow Coma Scale of a vented patient is 5 or less and/or first mention of a terminal wean by physician or family (NPP R-009 Care of the Patient After Death.)

1) The consideration of, and the discussion regarding the termination of medical treatment/support occurs between the responsible physician and the family *prior* to discussion about organ donation.
2) The physician is not associated with IOPO nor affiliated with hepatic or renal transplant programs.
3) The patient meets the established DCD criteria.
4) The responsible physician, according to hospital policy, has written a "Do Not Resuscitate" order

c. **Donor Suitability Evaluation**:

1. The IOPO coordinator, with the full knowledge and assistance of the attending physician, will:
   1) Review the hospital medical record.
   2) Perform an initial physical assessment.
   3) Verify the documentation of the family discussion and decision to withdraw support.
   4) The primary nurse and physician will document the decision to withdraw support , documentation that will include the following information:
      - Date and time of discussion
      - Name of legal next-of-kin or other legally designated surrogate
      - Next-of-kin's decision
      - Responsible physician's signature

d. Should the patient be deemed medically unsuitable for donation:
   1) The attending physician will be informed of the rationale for unsuitability.
   2) At the direction of the IOPO coordinator, nursing staff will document in the patient's medical record the rationale for declining the patient for DCD.

e. **Consent**:

1. The IOPO coordinator and appropriate hospital staff will conduct a team huddle to determine the most suitable designated requestor.
2. The designated requestor will approach the next-of-kin to initiate the consent process.
3. As part of the consent process, it will be determined which organs may be donated.
4. In addition the following information will be shared with the family:
   1) Complete explanation of the DCD and organ recovery process, answering any questions that the family voices.
   2) Death is expected to occur in the operating room suite.
   3) Organ recovery will take place five (5) minutes after declaration of death. .The patient/family is not charged for organ evaluation, allocation, or recovery.
   4) In the event that the patient does not expire within 60 minutes after discontinuation of support, *and* does not demonstrate a significant progression towards death, the organ donation process will cease. In this situation, the family will resume financial obligations associated with terminal care.
   5) The family will be given the opportunity to see their loved one after organ recovery has been completed.
5. The next-of-kin **agrees to donation**, the designated requestor will:
   1) Contact the Coroner per policy #CLN 2068, Coroner's Cases, prior to obtaining consent.
   2) Complete the consent for Organ and Tissue Donation after Circulatory Death form.

3) Conduct and document a thorough medical/behavioral history interview.
   2) 3) Notify the following people and services, in collaboration with the primary nurse:
      - Community Hospitals' staff/services:
        - Responsible physician/physician of record
        - House Supervisor, who will place the patient's ICU room on

"hold" pending outcome, in the unlikely event that the patient does not expire within 60 minutes
- Operating Room – charge nurse or nurse-on-call

Staff follow EMR (EPIC) workflow for Organ DCD and Tissue Donation

- Recovery surgeon and perfusionist.
- The patient's spiritual leader of choice, and/or a hospital chaplain

4) Provide time for the family to be with the patient.
5) If the next-of-kin **declines donation**, designated requestor will:
   1) Support the family's decision.
   2) Document the decision not to donate in the patient's hospital medical record
   3) Notify the responsible physician
   4) Thank the staff for their assistance.

f. **Donor Maintenance After Consent**:
   1) The physician of record will retain full responsibility for the patient until the patient is declared dead.
   2) The physician will make clinical judgments, including the administration of medications for comfort measures, according to the end of life protocol.
   3) The use of paralytics is prohibited.
   4) When diagnostics and maintenance measures are complete the patient, accompanied by his/her primary nurse will be moved to the operating room. The Respiratory Therapist will accompany the patient and bring a ventilator for use in the OR.
   5) Once in the OR, the patient will be cared for by the primary nurse, under the direction of the physician of record, as with any other terminal wean situation.
   6) An OR nurse will be present, in compliance with OR standards of care.

g. **Withdrawal of Support (Ventilatory and Hemodynamic)**:
   1) Withdrawal of support will only occur in the operating room suite.
   2) The organ recovery team will be on site and available prior to withdrawing support but will **not** be in the patient's OR suite during the withdrawal of support or the certification of death.
   3) The IOPO coordinator and the organ recovery team will assemble all necessary recovery equipment and prepare all perfusion/preservation solutions, to be held in wait.
   4) The OR staff will appropriately prep and drape the patient.
   5) During prepping/draping, the family will be supported by the IOPO coordinator. Family members who wish to go into the OR will be assisted to gown and glove.
   6) After draping, the family will be allowed to be with the patient and touch his/her face and hands; the family will be instructed not to touch draped and/or sterile areas.
   7) The primary RN will document withdrawal of support in the medical record
   8) During the withdrawal process, the OR nurse will remain in the OR according to OR standards of care and policies.
   9) The following withdrawal procedure will be utilized:
      - The ICU RN will administer Heparin 300 units/kg IV push if ordered by the physician.
      - The RN and/or RT will withdraw ventilator support and will discontinue all intravenous infusions excluding medications for comfort measures as ordered by the physician.
      - Cardiac monitoring and invasive blood pressure monitoring will be maintained.

h. In the unlikely event that the patient does not expire within 60 minutes, or fails to significantly progress toward death within 60 minutes:
   1) The ICU nurse in attendance will notify the Resource Coordination Administrator/House Supervisor
   2) The patient will be returned to his/her ICU room

3) If beds are in short supply, a huddle will take place between the ICU nurse, the House Supervisor and the appropriate med-surg nurse, in collaboration with the family, to determine the best placement for the patient at this time.

i. EMR documentation will continue in the current encounter. **Certification of Death**:
   a. The prompt and accurate diagnosis of cardiac arrest is extremely important since recovery of organs cannot take place until the patient meets the cardiopulmonary criteria for death. (See policy #NPP R-009, *Care of the Patient After Death*)
      1) Under no circumstances will an incision, for the purpose of organ recovery, be made until death is pronounced.
      2) Under no circumstances will cold perfusion catheters be inserted until after death has been pronounced.
      3) Under no circumstances will chest compressions be performed after the declaration of death.
         a. The physician or registered nurse declaring death will document the date and time of death in the patient's hospital medical record and a certificate of death will be completed.
         b. The family will be informed and support will be provided.
         c. Organ recovery may proceed five minutes after declaration of death.

j. **Recovery of Organs**:
   1) Recovery of organs will proceed after the certification of death.
   2) The recovery surgeon will be informed of the warm ischemic time, defined here as the time from pulselessness until the organs have been initially cooled and flushed.

Attachments: None

References:

1. Indiana Organ Procurement Organization, *Protocol for Donation after Circulatory Death*
2. Statement of the Institute of Medicine, *Non-Heart-Beating Organ Transplantation: Medical and Ethical Issues in Procurement*, 1997 (again in 2000)
3. *Healthcare at the Crossroads: Strategies for Narrowing the Organ Donation Gap and Protecting Patients*, Joint Commission on Accreditation of Healthcare Organizations, 2005
4. *Conditions of Participation; Conditions for Coverage: Identification of Potential Organ, Tissue, and Eye Donors – Questions and Answers*, Centers for Medicare & Medicaid Services, 2005
5. *Kennedy Institute of Ethics*, Volume 3, No. 2, 1993.
6. *Maximizing Organ Donation Opportunities Through Donation After Circulatory Death*, Critical Care Nurse, Volume 26, No. 2, April 2006.
7. *Evidence Based guideline Update: Determining Brain Death in Adults Report of the Quality Standards Subcommittee of the American College of Neurology2010*

Owned by: Network Donor Council Chairperson

Approved by:		
	Risk Management	Date: 2/4/14
	Infection Prevention	Date: 2/4/14
	Respiratory Services	Date: 3/4/14
	Patient Access	Date: 2/27/14

Approved by:	Medical Executive Committee Community Hospital East/North	Date:	2/3/14
	Medical Executive Committee Community Hospital South	Date:	5/2013
	Medical Executive Committee Community Heart and Vascular Hospital	Date:	2/4/14
Approved:	CNO Designee	Date:	3/2014
Approved:	_____ Network President and CEO	Date:	

Community
Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved for: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS: 2/8/12

NPP#: R-009
Page 1 of 7
EFFECTIVE: 7/17/12

TITLE: Care of the Patient after Death

Performed by:
1. RNs: may assess and complete forms and pronounce the patient at the time of death.
2. LPNs: may complete forms under direction of RN.
3. CT, PSP, PST may assist in preparation and transportation.
4. AP may initiate computer functions and documentation forms.

Purpose:
1. To establish procedures to be followed when a patient death occurs.
2. To provide information for:
   a. Pronouncement of death, time, and notification of physician(s), family, significant other, and appropriate hospital personnel.
   b. Coroner's cases and potential Coroner's cases
   c. Documentation, forms completion, and disposition of patient's chart.

Policy Statements:
1. When a death occurs and a physician is not present, the RN is responsible for the pronouncement of death.
2. Indiana Donor Alliance must be informed of all patient deaths. Staff of the donor procurement organizations are the ONLY people who should approach the family about organ donation. See CLN-2055 Organ and Tissue Donation.
3. The County Coroner MUST be notified if death occurs under special circumstances. See Procedure step F for listing of these circumstances.
4. The attending physician must be informed when the patient meets the criteria for Coroner's Case. See CLN - 2068, Coroner's Case for criteria.
5. If an autopsy is ordered then two originals of the Consent for the Autopsy must be completed. For further autopsy information refer to CLN-2054, Autopsies.
6. All funeral arrangements, including the first call to the funeral home must be made by the family or responsible party. The nurse may notify the funeral home when the body is ready to be picked up only after the nurse has been informed that the arrangements have been made by the family and that the family is ready for the release of the patient to the selected funeral home. If patient has no family or significant others, then nursing will contact Case Management and Social Services to determine the process.
7. Accounting of Disclosure form (accessed from the Community Health Network InComm (Intranet) Home Page must be completed for all patient deaths (May refer toCOMP: 004 HIPAA Accounting of Disclosures-Recording and Tracking). This is to be done for the designated funeral home, Coroner if coroner's case, and pathology if autopsy, Marion County Health Department, Indiana Organ Procurement Organization (IOPO) for organ procurement, tissue donation, and eye donation.
8. If upon death it is noted that the patient had restraints in the 7 days prior to death, notify management to complete the form #17922, "Hospital Restraints/Seclusion Form".

9. Patients transported to the morgue for holding until release must be placed in a shroud/body bag.

General Information:

1. Funeral home staff may transport the body of the deceased patient directly from the unit. In the event the funeral home cannot pick up the patient in a timely manner or there is an urgent need for the bed, then unit personnel may transport the body to the morgue/cold room(TIHH) for holding until transport can be completed.

Equipment:
Shroud Kit
Documentation forms.

Procedure

A. Pronouncement of Death Criteria and Notification
   1. Assessment criteria for pronouncing the patient dead:
      a. Absence of carotid pulse
      b. Absence of bilateral breath sounds
      c. No palpable blood pressure
      d. Pupils fixed and dilated
   2. Note time of death.
   3. Notify the attending/designated on-call physician directly.
      a. It is the responsibility of the RN caring for the patient to see that all attending/consulting concerned with the patient are notified. Refer to the chart as reference. Contact consulting physicians' office or pager to notify them of death. Document time and notification of physician in the electronic medical record(EMR) and Form N33, Care of the Patient After Death(available on Incomm under eforms).
   4. Coroner's Case or potential Coroner's Case – Inform physician. **Do nothing with the body until it is determined if the patient is a Coroner's Case.** (Refer to section on coroner's care).
   5. Family Members
      a. If family members are not present and cannot be contacted by telephone, contact Safety and Security to enlist the aid of the respective Police Department to assist in locating the next of kin.
      b. If family is not present,label belongings and flowers and hold on unit for family to pick up. If there is a delay, contactSafety and Security.
      c. Obtain consent for autopsy if ordered (CLN –2054, Autopsies)
      d. To comply with Indiana Anatomical Gift Act, follow CLN 2055 Organ and Tissue Donation.

B. Organ/Tissue Donation Referral Process (CLN-2055 Organ and Tissue Donation for additional information)
   1. Upon the death of every patient or when it is determined that death is imminent (ie call with all vented patients with a Glascow coma scale of 5 or less and/or at first mention from physician or

family of any terminal wean) the nurse or designee is to call: **1-800-356-7757, the Indiana Donor Alliance.**

2. Identify yourself by name and hospital, give the unit telephone number, and advise of the death or impending death.
3. Record the reference number and the name of the person who was on the call from Donor Alliance on N-33 form and on the multidisciplinary record.
4. A representative for the donor organization will contact the nurse and obtain a brief medical history on the patient to determine the donor suitability. Record the representative's name and the time on N-33 and the EMR.
5. If the patient is approved as a potential donor, follow the instructions of the IOPO representative.Exception: See CLN-2035 Donation Organs After Cardiac Death. If the patient is not approved as a donor, document this and the name of the person determining that the patient is not suitable on N-33 and the EMR.
6. If patient is a tissue or eye donor (or potential to be such a donor) transport patient to morgue with Security. Security then will facilitate and release body upon completion of donation.

C. Preparation of Body (**Non-Coroner's Case**)

1. If the patient was in ISOLATION at the time of death, refer to "Infection Control Manual" ICP #1 for special instructions and procedures in handling the "Isolated Death".
2. Radioactive Implant Patients: Patients who die with a Radioactive Implant in placewill not be prepared or removed from room. Call Radiation Safety Officer immediately (see phone number on patient door and chart.) Guidelines for preparation and removal will come from the Radiation Safety Officer.
3. Put dentures in place. (If this step is omitted because dentures are overlooked for some reason, the dentures should be sent with valuables to Safety and Security or family)
4. Remove drainage, feeding, and tracheotomy tubes. (Plaster casts should be cut, but need not be removed.) Venous access devices that are temporary, for example, triple lumen catheters or PICC's, need to be removed. For all lines that are removed, apply pressure at least 5 minutes. All permanent lines remain in, capped and clamped, for example, Port or Hickman.
5. Cleanse body of all excreta before family viewing and/or transportation to Morgue. All isolation precautions should be followed throughout all care.
6. In case of excessive drainage, apply or change dressings as indicated.
7. DO NOT TIE HANDS OR REMOVE IDENTABAND. (Fold arms across chest)
8. Remove all posts/jewelry from all piercings and send with valuables to Safety and Security or with family.
9. For all autopsies: receive autopsy consent; contact Safety and Security to inform them of need for autopsy, and place order in computer under Pathology for autopsy. Security will notify Pathology after business hours. At TIHH the house supervisor will be the contact.
10. In the event a patient dies when in transit or in a testing area prior to reaching the receiving unit, the sending unit completes the discharge process and the appropriate forms.
11. Attach the following to the chart:

a. County Health Department Provisional Notification of Death-Burial Transit
b. Community Form-Care of Patient after Death, N-33.
c. Permission for Release of Deceased to Mortician, N-86.

12. Fill out three identification tags. Tie one identification tag to the body, preferable site is the right great toe, one on outside of the shroud, and one to the clothing and/or personal effects.
13. Place patient in shroud, arms folded across chest. Secure another identification tag on the outside of the shroud. If patient is being picked up by funeral home from the unit, a shroud may not be needed. Some family members desire to allow their loved ones to remain clothed; share this requestwith the funeral home attendant.
14. If isolation, indicate "ISOLATION" on the tag. Place on the outside of the shroud.Write "Observe Body Fluid Precautions" if the patient was known to have one of the following disease processes at the time of death:
    a. Hepatitis (types A, B, C)
    b. Human Immunodeficiency Virus and AIDS related complex
    c. Tuberculosis
    d. Herpes
    e. Gonorrhea
    f. Syphilis (primary and secondary)
    g. Burkett's Lymphoma
    h. Kaposi's Sarcoma
    i. Arthropod-borne viral diseases
    j. Babesiosis
    k. Creutzfeldt-jakob disease
    l. Leptospirosis
    m. Malaria
    n. Rat-Bite Fever
    o. Relapsing Fever
    p. Y-Pestis
    q. Hemorrhagic fevers
    r. Rabies

D. Medical Death Certificate (See CLN-2068 Coroner's Case)
1. The Medical Death Certificate is to be completed in the computerized format by the physician. The access to this form requires the physician with the approved login information from the State Department of Health. If physician is a hospital employee they enter into the hospital HIPAA disclosure database.

E. **Transportation to Morgue/Non Autopsy**
1.If no autopsy or patient is not a coroner's case leave the chart on the unit to be picked up by Health Information Management. If patient is being taken to the morgue for release, then the pink copy of the Death Burial Transit form will remain with the chart. The mortician release form(N-86), Care of

the Patient After Death(N-33 and the other 2 copies of the Death Burial Transit form will accompany the body to the morgue.

2.Call Safety and Security to unlock morgue. Nursing unit will pick up cart and transport body to morgue. If nursing needs assistance in transporting or moving the patient, alert Safety and Security of such need.
3.Clean any soiling of the morgue cart during transporting of body. All necessary materials for maintaining standard precautions are available in the morgue area.

F. Coroner's Case/potential Coroner's Case (CLN-2068)
1. The County Coroner MUST BE NOTIFIED of all deaths under any of the following circumstances:
   a. Death stemming from any wound or injury – this includes any trauma, whether homicidal, suicidal, or accidental in nature, within the past year and one day of the initial injury.
   b. Death with a history of a fracture – which occurred within one year and one day preceding the death.
   c. Any sudden, unexpected death of a healthy child, including a young adult.
   d. Any death involving a history of known or suspected child abuse.
   e. Deaths relating to a disease that might constitute a threat to public health such as infectious hepatitis, infectious meningitis, or other highly communicable diseases.
   f. Death of inmates or inpatients of penal or state operated institutions. This will include the death of such patients who have been transferred to a hospital or extended care facility due to a condition contracted while in custody.
   g. Deaths involving the suspicion of criminal abortion.
   h. Deaths occurring during surgery or while under general anesthesia. This includes deaths in the Recovery Room if the patient has not regained consciousness from the anesthesia.
   i. Deaths relating to a disease or injury incurred through the deceased person's employment.
   j. Deaths resulting from any medical or surgical misadventure such as the administering of drugs, transfusions, dialysis, or other therapeutic or diagnostic procedures.
   k. Deaths occurring within the first 24 hours following admission or when insufficient history has been gathered to support a diagnosis.
   l. Unusual or unexpected deaths in which criminal or civil litigation is likely to follow.
   m. Any death in which the attending physician declines to sign a medical certificate of death.
2. Coroner's office must be notified of all deaths in the Emergency Department and in Behavioral Care Services. Fill out and fax the Marion County Coroner's Office Information Form.
3. Nurse or Administrative Partner will enter this information on the Care of the Patient After Death Form N-33, the name of the Coroner, date of notification, and his instructions (for example, autopsy to be done, release body to mortician, hold body, etc.).

For questions or concerns call the coroner, (Coroner's Office,). The Coroner will determine if the death will be investigated and certified on a Coroner's Death Certificate or if

the attending physician may routinely sign the death certificate. The attending physician may also notify the Coroner.

4. THE CORONER WILL DECIDE WHEN THE BODY CAN BE RELEASED TO:
   A. City Morgue
   B. Funeral Home
   Enter Coroner's decision on N-33 Care of the Patient After Death Form.

G. Preparation of Body (Coroner's Case)
1. Follow specific instructions of Coroner.
2. Do nothing to body until specific instructions from Coroner are given.
3. The personal valuables of deceased Coroner's Case patients will be received and signed for by the Deputy Coroner if the appropriate next of kin has not already received them.

H. Autopsy – CHE Units
1. When the physician has ordered an autopsy, originals of signed consent form and Autopsy Form (N-6) are needed. The appropriate family member or designee must sign the consent. Enter the order in the computer under Pathology – Order for Autopsy. ContactSafety and Security and transport the body to Morgue.
2. Deliver medical records to the Pathology Department Main Lab, Building 4. The computer entry will alert Pathology.
3. After hours and on weekends take medical records to Safety and Security.
4. Contact the funeral home and inform them that an autopsy is to be performed. The Pathology Department will contact the Safety and Security Department and the funeral home when the autopsy is completed.

I. Autopsy – CHN/CHS/TIHH Units
1. When an autopsy has been ordered at CHN/CHS/TIHH, gather all medical records as well as two signed original Consents for Autopsy form, and send all of these items via courier to the Pathology Department at CHE,
2. Enter the order in the computer under Pathology – Order for Autopsy. Contact the Safety and Security Department on weekends and after hours.
3. Contact the funeral home and inform them that an autopsy is to be performed and that pathology personnel will contact the funeral home directly when autopsy is completed.
4. Prepare the body for transport. Contact family designated mortuary to transport to East. If mortuary does not provide this service contact Safety and security, who will contact CHI designated mortuary for transport; Bell Mortuary.

J. Valuables
1. Check all closets, bedside cabinets, and valuables boxes for personal property. Tag all clothing with third identification tag and send to morgue with body and indicate on Form N-33. If family is present, give clothing and effects to them and record what is given and to whom on the form.

2. Check that all valuables are given to the family. If the family is not present, label valuables envelope (front and flap), list valuables placed in the envelope, date, sign, and send to Security. If rings cannot be removed, document on Form N-33.

Documentation:

Forms Completion:

1. Complete the following forms:
   a. N-86, Permission for Release of Deceased to Mortician.
   b. N-33, Care of the Patient After Death – complete all items, AP may complete all but #6 & #7; RN must complete #6 & #7.
   c. Indiana State Department of Health Provisional Report of Death and Burial Transit Permit. Complete section A and B.
   d. Marion County Coroner's Office Information Form – for all ED/BCS deaths
2. Record time of death, physician notification, and preparation of the body in the Multidisciplinary Notes.

Electronic Medical Record:

1. Complete care after death documentation
2. Notify environmental services when the body has been released from the room and complete the discharge as per hospital process.

RN to document the following in the EMR:

1. Absences of carotid pulse
2. Absence of bilateral breath sounds
3. No palpable blood pressure
4. Pupils fixed and dilated
5. Time of death
6. Time and notification of physician(s)

References:

1. Communication with Coroner's Office
2. IOPO/HCHA Organ Procurement Regulations 2010
3. Indiana State Department of Health

Approved by:	IV/Oncology Practice Committee	Date: 2/2012
	Infection Control	Date: 2/2012
	Risk Management	Date: 2/2012
Approved:	NPP Steering Committee	Date: 6/13/12

HOSPITAL PROCUREMENT AGREEMENT

(ORGAN, TISSUE AND EYE)

This Hospital Procurement Agreement (Organ, Tissue and Eye) ("Agreement") is made this 1st day of November 2010 between Community Hospitals of Indiana, Inc. and its affiliates and subsidiaries ("Hospital") and Indiana Organ Procurement Organization, Inc. ("IOPO").

RECITALS

A. IOPO is an Indiana nonprofit corporation and is a freestanding Organ procurement organization (within the meaning of 42 C.F.R. § 413.200 and § 486.302) which is the federally qualified Organ procurement organization designated for the donation service area within the State of Indiana in accordance with Section 371 of the Public Health Service Act (42 U.S.C. § 273) ("Donation Service Area");

B. IOPO is a member of the Organ Procurement and Transplantation Network ("OPTN") established under Section 372 of the Public Health Service Act (42 U.S.C. § 274), the nonprofit corporation composed of transplant centers, organ procurement organizations, and histocompatability laboratories, with the purpose of increasing the availability and access to donor organs;

C. OPTN is administered by the United Network for Organ Sharing ("UNOS"), a nonprofit corporation, which, as the OPTN contractor, manages the national Organ transplant waiting list, manages clinical data in a secure environment, works to improve the quality processes of OPTN, and facilitates the Organ allocation, matching and placement process for human Organ transplants;

D. IOPO conducts Tissue and Eye procurement services and is accredited by the American Association of Tissue Banks ("AATB"), and complies with requirements of the United States Food and Drug Administration ("FDA") in conducting Tissue and Eye procurement activities for transplantation, therapy, medical research or educational purposes;

E. The purposes of IOPO are to perform and coordinate the identification of donors, and facilitate the retrieval, procurement, preservation and transportation of Organs, Tissue and Eyes for transplantation, therapy, medical research or educational purposes, to work with the OPTN and UNOS in the allocation and placement of Organs available for transplant, and to educate medical personnel and the general public regarding donation and transplantation issues;

F. Hospital participates in the Medicare and Medicaid program and desires to be in compliance with Section 1138 of the Social Security Act (42 U.S.C. § 1329b-8) and the rules of the Centers For Medicare and Medicaid Services ("CMS") for hospital conditions of participation in Medicare and Medicaid programs (42 CFR Part 482.45);

G. For the purposes of this agreement, Hospital is defined as the facilities operated by and for Community Health Network and are designated as Community Hospital East, Community Hospital North, Community Hospital South, the Indiana Heart Hospital and are located within the Donation Service Area of IOPO;

H. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs, Tissues and Eyes donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in Hospital; allowing families of Potential Donors to be informed of the potential for Organ, Tissue, or Eye donation; and maintaining Potential Donors under the direction and guidance of IOPO while necessary determinations of medical suitability, testing and placement of Organs can take place. Hospital agrees to cooperate with IOPO in supporting a patient's right to donate Organs, Tissue and Eyes when an appropriate declaration of gift has been made by the patient, even if that declaration of gift is contrary to the wishes of the next of kin, and, allowing IOPO to appropriately approach all families of medically suitable Potential Donors in order to obtain the consent to donate Organs, Tissue and Eyes, when appropriate, for suitable Potential Donors under eighteen years of age or where no declaration of gift can be found. Hospital hereby requests that IOPO recover all Organs from Donors who die within Hospital that are determined to meet the requirements of medical suitability; and

I. In situations where organs, tissue and eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consents, procurement may proceed for medical or dental education, research, the advancement of medical or dental science, or therapy.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants contained herein and for other good and valuable consideration, the parties hereby agree as follows:

1. Definitions. For purposes of this Agreement, the following words shall have the meanings indicated herein:

a) "Brain Death" shall mean the condition of death occurring when increased intracranial pressure is sufficient to impede the flow of blood into the brain causing cellular death of the brain tissue and/or herniation; characterized by the absence of electrical activity in the brain, blood flow to the brain, and brain function as determined by the clinical assessment of responses therefore, resulting in complete, irreversible cessation of all functions of the entire brain, including the brain stem.

b) "Clinical Indicators" shall mean the following criteria for a patient with severe, acute brain injury and (i) who requires mechanical ventilation; (ii) is in an intensive care unit, critical care unit or emergency department; (iii) has clinical findings consistent with a Glasgow Coma Score that is less than a threshold of 5, regardless of central nervous system depressants or an induced coma, or for whom the attending physicians are evaluating a diagnosis of brain death, or for whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's or guardian's decision.

c) "Conversion Rate" shall mean the number of Potential Donors meeting the medical suitability requirements of IOPO, who actually donate Organs compared to all eligible Organ Donors who die in Hospital, including those for whom consent to donate is not obtained, expressed as a percentage.

m) "Tissue" shall mean other transplantable and non-transplantable tissues of the human body, excluding Organs, and including but not limited to whole heart for heart valves, vascular tissue, connective tissues, skin and bones.

2. Notice of Donor Availability and Consent. Hospital shall, consistent with applicable laws and regulations, cooperate with IOPO in the recovery of Organs, Tissues and Eyes donated from patients who die in the Hospital. Hospital shall cooperate with IOPO to prepare and implement appropriate policies that support the mechanism of the donation of Organs, Tissues and Eyes.

a) Hospital shall provide Timely Referral to IOPO as soon as possible of every individual whose death is imminent or who has died (including calling prior to or at the time Brain Death is declared), in the Hospital. In addition, Hospital shall provide Timely Referral to IOPO or the named donee, if any, when Hospital becomes aware that a person in transit to Hospital is identified as a Potential Donor. IOPO shall preliminarily determine, based upon medical and patient information provided by Hospital, the medical suitability of each Potential Donor for Organ, Tissue and Eye donation according to requirements utilized by IOPO.

b) The determination of death for a Potential Donor shall be made by the Donor's attending physician or by the physician responsible for certifying death at the Hospital. Such physician shall not participate in any procedure relating to removal or transplantation of any Organs, Tissues, or Eyes. IOPO shall not participate in the determination of death of any potential Organ, Tissue or Eye Donor. Notification of a determination of death shall be written into the patient's chart upon pronouncement. IOPO shall verify the determination of death according to applicable State and federal laws prior to proceeding with any anatomical recovery.

c) Hospital shall allow IOPO to determine the medical suitability of any Potential Donor and to use such portable laboratory equipment as may be necessary to facilitate such determination.

d) Hospital shall ensure, in collaboration with IOPO and consistent with federal and state laws, rules and regulations, that a patient's right to donate Organs, Tissues, and Eyes is fulfilled when appropriate declaration of gift is noted, or that the family of each Potential Donor, or person legally responsible for a Potential Donor, is informed of the potential to donate Organs, Tissues, and Eyes, or to decline to donate when the appropriate declaration of gift cannot be found. When a family member or person legally responsible for a Potential Donor is informed about the procedures for making a gift of Organs, Tissue or Eyes, the fact that the family member or representative was so informed shall be noted in the Potential Donor's medical chart. Hospital and IOPO shall encourage discretion and sensitivity with respect to the circumstances, views and beliefs of the families of Potential Donors.

e) IOPO and Hospital shall act in good faith to support a patient's right to donate, and fulfill a patient's wishes to donate anatomical gifts in accordance with the Indiana Uniform Anatomical Gift Act, Indiana Code 29-2-16-2 et seq. (the "Act"). The Act prevents a patient's family from altering a gift declared in writing by an individual

under the provisions of the Act. Under the provision of the Act, IOPO shall attempt to obtain any documentation of patient's declared decision to donate, including applicable designations on an individual's driver's license, which may be determined from the Bureau of Motor Vehicles registry or the Donate Life Indiana registry and honor such request in accordance with applicable requirements of law.

f) IOPO shall determine whether a Potential Donor has made a written anatomical gift, and, if so, whether the Potential Donor has subsequently revoked the anatomical gift in writing, in consultation with the family or guardian of the Potential Donor and with any other sources that are reasonably available, and any information received by IOPO shall be provided by IOPO to Hospital, the attending physician, and the physician who certified the Potential Donor's death if there is not an attending physician, and must be documented in the Donor's medical chart.

g) Hospital shall work cooperatively with a Family Services Coordinator in requesting consent for any potential anatomical donation from a Potential Donor's family, when no declared intent by the Potential Donor can be found. If Hospital has actual notice of contrary intent in writing by a Potential Donor, or that the potential donation is opposed by a member of the Potential Donor's family or guardian, which member is of the same or prior class under Indiana law as the family member or guardian granting the consent, Hospital shall notify IOPO of such contrary intent. This shall not prevent IOPO from presenting options for donation to a Potential Donor's family members or guardian.

h) In the event that Organs, Tissue or Eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consent, procurement and all examinations necessary to assure suitability may proceed for donation for medical or dental research or education, the advancement of medical or dental science, or therapy.

3. Organ, Tissue and Eye Procurement. The procedures undertaken to procure donated Organs, Tissue and Eye shall be supervised by PTC, or other professional procurement personnel, provided by and or contracted by IOPO, with specialized training in transplantation, Donor evaluation and management and Organ, Tissue and Eye preservation, to coordinate Organ, Tissue and Eye procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ, Tissue and Eye procurement personnel perform such activities. Hospital agrees to grant access, on an emergency basis in accordance with its Medical Staff rules and regulations, to physicians and other Organ, Tissue and Eye procurement personnel participating in the procurement procedures, case management, and all ancillary activities. Hospital and IOPO agree to cooperate in complying with reasonable requirements of other health care providers and payors in connection with Organ, Tissue and Eye procurement pursuant to the terms of this Agreement.

4. IOPO Obligations. IOPO, consistent with its purposes of performing and coordinating the retrieval, preservation and transportation of Organs, Tissues and Eyes will follow the system of locating prospective recipients pursuant to the rules of the OPTN for available Organs, and

educating medical personnel regarding donation issues, shall:

a) provide twenty-four (24) hour availability of a qualified IOPO staff member or PTC to evaluate and determine the medical suitability for Organs, Tissues and Eyes from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ, Tissue and Eye recovery, provide technical assistance during recovery and initiate Organ, Tissue and Eye preservation and recovery;

b) provide twenty-four (24) hour availability of a Family Services Coordinator and/or other qualified IOPO staff member to appropriately inform the family of a Potential Donor of the right to donate or to decline to donate, to seek to obtain consent for donation from the family or person legally responsible in accordance with applicable law, and with discretion and sensitivity to the family or legal guardian.

c) provide in-service training for Hospital personnel involved in Organ, Tissue and Eye donations;

d) educate Hospital personnel regarding donation and transplantation issues;

e) if requested, approve or provide on at least an annual basis a course in the methodology for approaching Potential Donor families and requesting Organ and Tissue donation for the purposes of training Hospital personnel to become Designated Requestors, which training shall also be designed in conjunction with the tissue and eye bank community, if Hospital chooses to use Hospital personnel to perform such tasks;

f) provide a physician or other qualified and trained personnel to assist in the medical management of the Potential Donor during the time of actual procurement of Organs, Tissues and Eyes and provide assistance to physicians who are members of the Medical Staff of Hospital to provide such services, and IOPO's Medical Director shall provide oversight and assistance in the clinical management of a Potential Donor when the Hospital physician on call is unavailable;

g) ensure that IOPO personnel and IOPO contractors providing services under this Agreement are trained in the proper methods necessary for Donor screening, determining medical suitability, requesting consent for donation, procurement, transportation and preservation of Organs, Tissue and Eyes, efficient placement of Organs, Tissue and Eye, and oversight of Organ, Tissue and Eye recovery;

h) determine whether there are conditions that may influence or affect the medical suitability and acceptance of a Potential Donor;

i) to the extent reasonably practical, obtain the medical and social history of a Potential Donor;

j) review the medical chart of a Potential Donor and perform a physical examination of a Potential Donor;

k) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;

l) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ or Tissue recovery;

m) if IOPO recovers Organs from a DCD Donor, IOPO shall maintain and follow protocols for evaluating DCD Donors; for withdrawal of support, including the relationship between the time of consent to donation and the withdrawal of support; the use of medications and interventions not related to the withdrawal of support; the involvement of family members prior to Organ recovery; and criteria for the declaration of death and time period that must elapse prior to Organ recovery;

n) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs and Tissues after their procurement;

o) utilize Organs procured at Hospital in accordance with the rules and requirements of OPTN and UNOS, and requirements of law, to recipients deemed suitable in accordance with sound medical practice;

p) utilize Tissues procured at Hospital in accordance with sound medical practice and in accordance with standards recognized by the FDA and AATB;

q) if requested by Hospital, provide Hospital with information as to the eventual disposition of all Organs procured at the Hospital;

r) reimburse Hospital at a rate consistent with national Organ procurement standards that are reasonable and customary for the Indiana region as determined by American Medical Bill Review ("AMBR"), for all costs associated with procurement of Organs from Donors preliminarily approved as medically suitable from and after the time of death of the Donor is determined and proper consent is obtained, in accordance with existing applicable CMS regulations;

s) pay private physicians not otherwise compensated through Hospital for reasonable and customary procurement fees for services related to procurement activities, unless IOPO and a physician have entered into a separately negotiated agreement for charges related to procurement activities;

t) make arrangements for histocompatibility tissue testing and testing for potentially transmittable diseases according to the current standards of practice to determine the medical acceptability of the donated Organs for the purposes intended, which shall be performed by a laboratory that is certified in the appropriate specialty or subspecialty of service and meeting the requirements specified by UNOS, in accordance with the guidelines specified by the Center for Disease Control and other applicable laws and regulations;

u) send complete documentation of Donor information including Donor's blood type and other vital data necessary to determine compatibility for purposes of transportation, the complete record of Donor's management, documentation of consent, documentation of the pronouncement of death, and documentation regarding determining Organ quality to the Transplant Center that will utilize each Organ; and two individuals, one of whom must be an IOPO employee, must verify that the documentation that accompanies an Organ is correct;

v) conduct reviews, on at least a monthly basis, of death records in every Medicare and Medicaid participating hospital in its Donation Services Area that has a Level I or Level II trauma center or 150 or more beds, a ventilator and an intensive care unit (unless the hospital has a waiver to work with an Organ procurement organization other than IOPO), with the exception of psychiatric and rehabilitation hospitals; to make an assessment of the medical charts of deceased patients to evaluate the potential for Organ donation; and in the event that missed opportunities for donation are identified, IOPO, working with Hospital, shall implement actions reasonably necessary to improve performance in identifying such opportunities; w) establish written policies to address the process for identifying, reporting, thoroughly analyzing and preventing adverse events that may occur during the Organ and Tissue donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ and Tissue donation;

w) maintain a toll-free telephone number (to facilitate the central referral of Organ, Tissue and Eye donations within the IOPO Donation Service Area; and

x) either directly or through a contract with an answering service, shall cause Organ, Tissue and Eye donation referrals to be referred to IOPO and its on-call staff.

5. Additional Hospital Obligations. In addition to those obligations set forth in Section 2 of this Agreement, Hospital shall:

a) comply with the requirements of Section 1138 of the Social Security Act (42 U.S.C. § 1320b-8) and the regulations of the Centers for Medicare and Medicaid Services; all anatomical gift legislation of the State of Indiana; and other legal requirements applicable to Organ, Tissue and Eye donation;

b) allow IOPO to use ancillary laboratory facilities, other than any available at Hospital, for tests of Organ function, blood typing, and other indicated clinical studies of Potential Donors as directed or requested by IOPO;

c) maintain certification of Hospital laboratory testing under the Clinical Laboratory Improvement Amendments of 1988 ("CLIA") and regulations of the Centers for Medicare and Medicaid Services, 42 C.F.R. Part 493.

d) in a timely manner provide intensive care or other clinical support for optimum maintenance of Potential Donors prior to Organ, Tissue and Eye procurement, to follow procedures and protocols as specified by IOPO for Organ, Tissue and Eye procurement;

and work cooperatively with IOPO in the optimum maintenance of Potential Donors while necessary testing and placement of potential donated Organs takes place;

e) shall adopt a protocol for DCD Donors, and notify IOPO of Hospital's DCD protocol, and to take all steps required under such protocol for determinations of death as provided in subsection 5. (f) below;

f) in a timely manner provide physicians to determine the death of Potential Donors in compliance with applicable state law and in accordance with standard medical practice;

g) work cooperatively with IOPO on providing access to Potential Donor medical records, in providing appropriate access to Hospital's information system;

h) provide IOPO with wired or wireless secure high-speed internet connection within the Hospital, at no charge to IOPO, for the purpose of facilitating the evaluation, maintenance, recovery, placement, and medical charting of Donors, in order for IOPO to provide Donor information to UNOS, and, if Hospital cannot provide a high speed Internet connection, Hospital agrees to work with IOPO to make the best alternative Internet connection available, which could include wireless Internet access cards or a dial-up connection;

i) provide an operating room with staff if needed (including surgical, anesthesia, and nursing) and materials deemed appropriate by IOPO for performing cadaveric Organ recovery, and assistance in performing all reasonably necessary tests and examinations, and if Hospital does not have appropriate operating room facilities, to follow procedures and protocols as specified by IOPO until such time as a potential Donor can be transported to another medical facility with appropriate facilities;

j) provide an itemized bill of all services for each Organ or Tissue Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ or Tissue Donor, or person financially responsible for payment of the expenses for medical and surgical care for the Donor, is not charged or billed for expenses related to Organ or Tissue donation and to furnish to IOPO, upon request, an itemized statement of expenses billed to the Donor family or other responsible party, relating to the Donor's medical and surgical care and treatment to confirm that no such charges or bills were remitted, and to limit the total facilities or other charges for the procurement of Tissues to an amount not greater than $1,200;

k) work cooperatively with IOPO in the education of Hospital staff and the community regarding donation issues;

l) enter a notation in a patient's chart when Timely Referral is provided to IOPO;

m) cooperate with IOPO and provide the assistance of at least one qualified Hospital employee to assist in verifying that documentation, including Donor blood type and other vital data necessary to determine compatibility for purposes of transplantation,

specified in subsection 4. (u) of this Agreement that accompanies an Organ to a Transplant Center is correct;

n) cooperate with IOPO in performing death record reviews as specified in subsection 4. (v) of this Agreement; and, if required, to cooperate with IOPO in implementing actions deemed reasonably necessary to improve the opportunities for identifying Potential Donors; o) cooperate with IOPO in identifying, reporting, analyzing and preventing adverse events that may occur during Organ, Tissue or Eye donation at Hospital, as specified in subsection 4(u) of this Agreement, and cooperate with IOPO in taking all steps deemed reasonably necessary to prevent the repetition of adverse events during Organ or Tissue donation at Hospital; and

o) prepare and implement written policies supporting a program for monitoring the effectiveness of its Organ donation and procurement program by collecting and analyzing records regarding Potential Donors and referrals to IOPO, and Hospital's Conversion Rate data, and, where possible, taking steps to improve the Conversion Rate

6. Retention and Access to Records. In accordance with the Omnibus Reconciliation Act of 1980, 42 U.S.C. § 1395x(v)(I) and regulations thereunder, IOPO and Hospital agree that each shall retain and for four years after services are furnished by either hereunder, shall allow the Comptroller General of the United States and the United States Department of Health and Human Services, and their duly authorized representatives, access to this Agreement and to such of the books, documents and records of each as are necessary to verify the costs of services performed hereunder, provided that the said access is required by the cited law and regulations and further provided that the request for access complies with the procedural requirements of those regulations.

7. Independent Contractors. In the performance of all obligations hereunder, the relationship of Hospital and IOPO shall be that of independent contractors, and neither shall be deemed to be the partner or agent of the other, and no party shall withhold or in any way be responsible for the payment of any federal, state, or local income or occupational taxes, F.I.C.A. taxes, unemployment compensation or workers compensation contributions, or any other payments for or on behalf of any other party or any person on the payroll of any other party.

8. Professional Liability. IOPO and Hospital shall each, at all times, qualify and comply with the procedures to be and remain qualified health care providers pursuant to the Indiana Medical Malpractice Act, as amended, Indiana Code § 34-18-1-1 et seq. and shall maintain professional malpractice liability insurance coverage or other qualifying financial responsibility in accordance with the applicable liability limits or securities as specified therein, and pay the annual surcharges levied by the Indiana Department of Insurance.

9. Indemnification. Hospital and IOPO shall protect, defend, indemnify and hold harmless the other party from and against all claims, losses, demands, damages and causes of action, including reasonable attorney fees arising or in any way resulting from the indemnifying party's willful or negligent acts or omissions or the acts of the indemnifying party's agents or employees, in providing services pursuant to this Agreement. Said indemnification shall be limited to the maximum exposure permitted under Indiana Code § 34-18-1-1 et seq., unless insurance coverage in a greater amount is possessed by the indemnifying party.

10. Governing Law. This Agreement shall be controlled by and construed under, the laws and regulations of the State of Indiana and applicable federal laws and regulations.

11. Compliance with Social Security Act. The parties agree that all provisions of this Agreement shall be interpreted in such a manner as to comply with the requirements of Section 1138 of the Social Security Act, as added by Section 9318 of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. § 1320b-8), and rules or regulations adopted pursuant to that law relating to Organ procurement.

12. Confidentiality of Patient Records. The parties agree to maintain the confidentiality of patient records pursuant to state and federal laws and regulations. However, to the extent permissible, the parties agree to cooperate in the exchange of information and records as may be necessary to carry out the terms of this Agreement, including obtaining information for inclusion in any IOPO originated donation chart as required by federal law. IOPO may disclose Donor medical and patient information to physicians providing treatment for Organ, Tissue or Eye recipients to entities that process or distribute Tissue or Eyes, to Transplant Centers receiving Organs, Tissue and Eyes, to the local coroner, and as may otherwise be required by applicable laws or regulations. IOPO may disclose medical and billing information to institutions providing reimbursement of expenses related to Organ donation and procurement.

13. Termination. This Agreement shall remain in effect until terminated by either party. Termination may be made by either party upon 90 days prior written notice to the other.

14. Waiver. The failure of any one party hereto to enforce any breach or to enforce any lack of performance of any covenants or obligations contained herein shall not constitute the waiver of that breach or of any similar subsequent breach of this Agreement.

15. Amendment. This Agreement represents the entire agreement between the parties hereto, and supersedes any prior stipulation,agreement, or understanding of the parties, whether oral or written. Any modification of this Agreement shall be invalid unless stated in writing and signed by both parties hereto.

16. Notice. All communications, notices and demands of any kind which either party may be required or desires to give or serve upon the other party shall be made in writing and sent by registered or certified mail, postage prepaid, return receipt requested, to the following addresses:

HOSPITAL

Community Hospitals of Indiana, Inc.
1500 North Ritter Avenue
Indianapolis, IN 46219
Attn: Contracts Management, Network Purchasing

IOPO:

Lynn Driver, President/CEO
Indiana Organ Procurement Organization, Inc.
3760 Guion Rd
Indianapolis, IN 46222

Either party hereto may change its address specified for notices herein by designating a new address in accordance with this paragraph

17. Separable Provisions. If any provisions hereof shall be, or shall be adjudged to be, unlawful or contrary to public policy, then that provision shall be deemed to be null and separable from the remaining provisions hereof, and shall in no way affect the validity of this Agreement.

18. Discrimination. The parties hereby warrant that each party is and shall continue to be in compliance with the Civil Rights Act of 1964 and the Rehabilitation Act of 1973. No person shall, on account of race, color, religious creed, national origin, ancestry, sex, handicap or age be unlawfully excluded from participation in any program sponsored by either of the parties of this Agreement.

19. Debarment. IOPO and Hospital each represents and warrants to the other, that neither it nor any of its affiliates, officers, directors, subcontractors, or employees, is barred from participating in federal or state health care programs, or has been convicted of a criminal offense with respect to health care reimbursement. IOPO and Hospital shall notify the other immediately if the foregoing representation becomes untrue, or if it is notified by the Office of the Inspector General of the Department of Health and Human Services or other enforcement agencies that an investigation of IOPO or Hospital has begun which could lead to a sanction, debarment, or conviction.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the day and year first written above.

COMMUNITY HOSPITALS OF INDIANA, INC.

By: _____
Steve Bell, Vice President, Supply Chain

INDIANA ORGAN PROCUREMENT ORGANIZATION, INC.

By: _____
Lynn Driver, President and CEO

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 19

DIVERSION POLICY

"19. **Diversion Policy**: The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 19 are met with a copy of the Community Hospital East diversion policy. The Emergency Department Director has signed the included letter affirming that the hospital will not be on diversion status more than 5% of the time. According to the data provided in the application, Community Hospital East was on diversion for 2.8% of the time in 2013.

Community Health Network

Community Hospital East
1500 North Ritter Avenue
Indianapolis, Indiana 46219-3095
317-355-1411 (tel)
eCommunity.com

June 13, 2014

William C. VanNess II, M.D.-Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

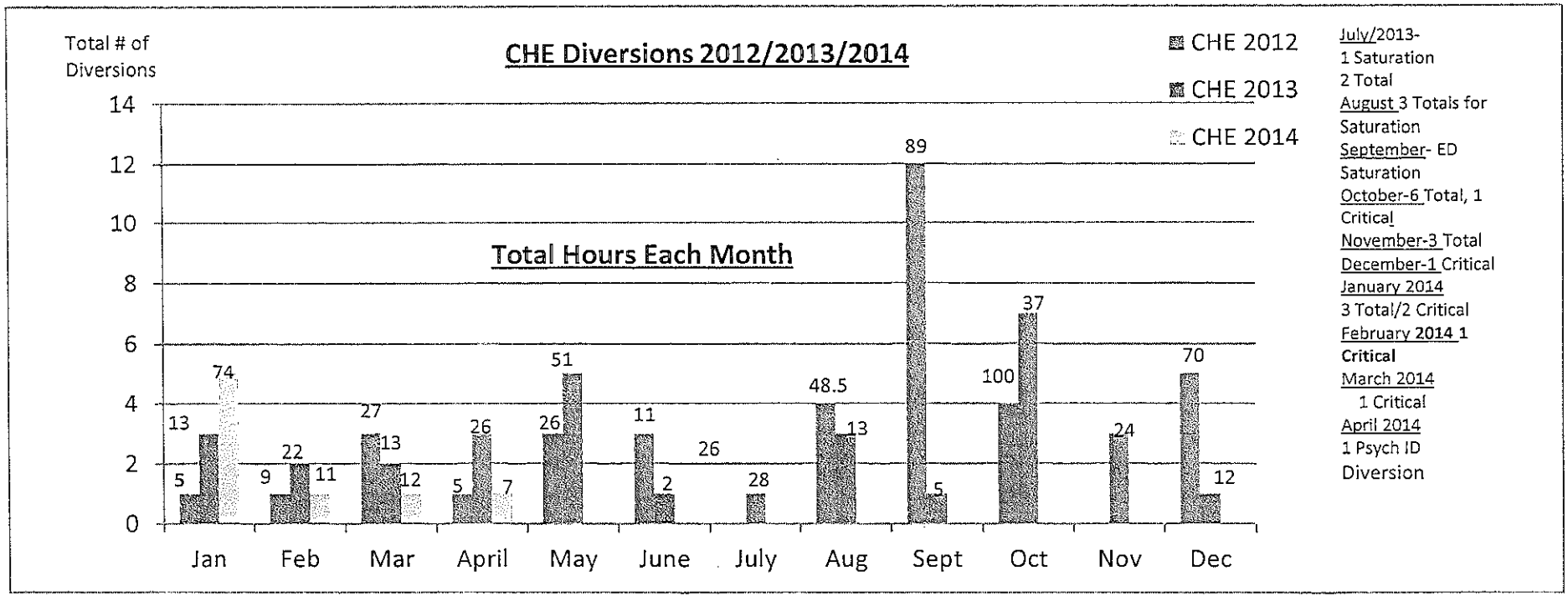
Subject: Affirmation of Diversion Standards for Level III Trauma Center "In the Process" application

Dear Dr. VanNess:

The purpose of this correspondence is to affirm that Community Hospital East has a Diversion Policy and absolutely will not be on diversion status more than 5% of the time.

Respectfully,

Michael Kuhn, MBA, MHA, BA, RN
Emergency Department Director
Community East



July/2013-
1 Saturation
2 Total
August 3 Totals for Saturation
September- ED Saturation
October-6 Total, 1 Critical
November-3 Total
December-1 Critical
January 2014
3 Total/2 Critical
February 2014 **1 Critical**
March 2014
1 Critical
April 2014
1 Psych ID Diversion

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 2/9/09; 5/23/12

CORP#: CLN-2087
Page 1 of 6
EFFECTIVE: 1-16-14

TITLE: READY TO SERVE/DIVERSION (AMBLUANCE DIVERSION)

Purpose:
To provide a plan for the orderly arrangement of staffing and patient placement during any situation that has the potential to cause a break in the provision of essential patient care and services. Examples include (but not limited to): a winter storm warning, internal or external disasters, Red Light Bed Alert and ambulance diversion.

Policy Statements:
1. The provision of high quality patient care is the primary focus of the Community Health Network (CHNw).
2. All departments that support patient care will maintain a roster which includes staff phone numbers, distance from the hospital and travel time to reach the hospital.
3. Staffing level that support patient care will be addressed if there is a Red Light Bed Alert, winter storm warning, code internal or external, or ambulance diversion.
4. In rare instances the need to consider diversion may be due to untoward patient volumes, high acuities, and compromised physical and/or available resources either in acute care or in the emergency department. In these situations, when there may not be sufficient patient beds and/or patient care staff to safely care for any additional patients, the delivery of ambulance patients to a facility may be temporarily diverted. The rationale of such a diversion is to allow optimal patient care, while causing the least amount of hardship to other hospitals, including other facilities in the CHNw, or to EMS providers.
5. When diversion is being considered:
   a. Only one (1) of the large metropolitan hospitals (excluding Eskenazi) will be on diversion at any one time; this includes Community Hospital East (CHE), St. Francis, St. Vincent, and Methodist.
   b. Only one (1) of the CHNw hospitals – East, North, and South –will be on diversion at any one time.
   c. In a rare instance when patient safety dictates more than one facility to divert at once negotiation and collaboration occurs between sites and leaders, eg ED Directors, Nurse Managers, and Facility President, frequently to remedy the situation. The CHE House Supervisor, after collaboration with DART is empowered to make whatever decisions are necessary to avoid diversion, this may include mandating certain patient placements or staffing patterns.
6. A recommendation for diversion is made by the Emergency Department (ED) Director after receiving data from the ED physician, the ED Patient Care Coordinator (PCC)/Charge Nurse, and the House Supervisor, The ED Director then communicates and collaborates with the Vice President (VP) of Patient Care Services or designee for that facility to finalize the decision and determine the official diversion status, ie total or critical. The Administrator on call will also be notified by the House Supervisor after hours. The cooperation of all site departments is necessary in order to implement this process. All patient care units, and all other applicable ancillary units, are expected to cooperate, negotiate in good faith, and work toward the common goal of managing patient flow and avoiding diversion.

General Information:

1. **DIVERSION** (ambulance diversion): The process of requesting EMS units to temporarily refrain from transporting incoming ambulance patients to a particular facility. Most often, diversion is due to unmanageable patient volumes, acuities, compromised physical resources or environment, Per agreement with metropolitan Indianapolis hospitals and EMS providers, there are four (4) recognized categories of diversion:
   a. Critical Care Diversion – Diversion of patients likely to require the most intense level of care and services, and likely to be admitted to critical care beds and/or monitored beds.
   b. Total Diversion – Diversion of all incoming ambulance patients. (NOTE: In the case of the following patients, the situation may be evaluated on a case-by-case basis: laboring mothers, patients in cardiac or respiratory arrest, patients in extremis, or ambulances which are in very close proximity to the hospital.)
   c. Psych Diversion – At Community Hospital North (CHN), times exist when the Behavioral Health Pavilion must divert patients. In these instances, the Medical Director and/or Executive Director for Behavioral Health are in charge of making the decision and notifying the House Supervisor at CHE to initiate the diversion.
   d. Cath Lab Diversion – Due to equipment failure in this department, diversion of patients with complaints likely to require this department's services is called and EMS units are alerted to divert those patients in order that they receive optimum care.
   e. Specific Resource Diversion – This is not an officially recognized "diversion" status in the community at large. For example, CT scanner is non-functional or both CT scanners at CHE are not functioning. Diversion of patients with complaints likely to require that resource is called and EMS units are alerted to divert those patients in order that they receive optimum care. (in CT example, stroke, and head injury). This type of diversion lasts only until the resource/issue can be resolved.
2. **BEDS/PATIENT FLOW** - Bed Alerts are a declared situation and electronic communication is sent to alert the Network.
   a. YELLOW LIGHT - approximately 91% occupancy of core beds.
   b. BLUE LIGHT - indicates the number of ready/available beds exceeds the number of available staff.
   c. RED LIGHT - nearing 100% occupancy; indicates the number of inpatients or admissions has exceeded the number of beds available.
   d. Updated Bed Aggregation numbers for each facility are maintained at CHE in the House Supervisor's office.
   e. The CHE House Supervisor is responsible for initiating the Network Alert daily.
3. **DART (Diversion Avoidance Response Team)**
   a. The DART group convenes in person and/or via telephone when census/acuity is high, and diversion is a threat. The group's goal is avoiding diversion by whatever means possible, and they are empowered to do so by Senior Leadership. A meeting of this group is requested when it is felt that diversion issues may arise soon if plans are not implemented to alleviate patient overload. NOTE: If a diversion decision is needed emergently, the ED Director in consultation with the facility VP of Patient Care Services may make that decision emergently and DART can be convened forthwith to work on solutions to end the diversion status as quickly as possible.
   b. The DART is comprised of:
      - House Supervisor
      - Emergency Department Clinical Director or designee
      - Nursing Site Leaders
      - Ancillary Site Leaders, eg., Case Management, Environmental Services
      - Facility President

- Site-specific personnel as designated by Facility President

4. **EMERGENCY STAFFING PLAN** - consists of:
   a. Holding essential staff over for duty on subsequent shifts
   b. And/or recruiting staff from alternative sources within the hospital network
   c. And/or requesting transportation service through Security Dispatch for staff essential to patient care and who are unable to provide their own transportation
   d. And/or providing lodging quarters, supplies, food, and compensation for staff, volunteers, and contracted service employees
   e. The hospital may provide transportation for staff needed for essential patient care and services after all efforts for self-transportation have been exhausted. When making arrangements to pick up staff, the network commits to making arrangements to take staff back home via 4-wheel drive vehicles or prepaid taxi. However, the network cannot commit to the exact time staff will be taken home. The network cannot guarantee that there will be a sufficient number of 4-wheel drive vehicles (or taxi service) available to meet the demand for pick up and return.
5. CODE INTERNAL can include, but is not limited to loss of communications, utility failure (ie electric, water, medical gas, HVAC), bioterrorist threat, chemical spill or communicable disease outbreak. A Code Internal is a situation that has potential to disrupt the normal course of business, cause damage or create casualties.
6. CODE EXTERNAL can include but is not limited to bus/plane or multiple auto accident (resulting in patient influx), release of a toxic substance, bioterrorist attack terrorist attack or incident causing multiple injuries/casualties. A Code External at one site does not mean there needs to be a Code External initiated at all sites.
7. Electronic communication devices are used to notify the network of disasters, bed alerts, etc.
8. PAY PRACTICES: refer to Community Health Network Human Resource Policy and Procedure Manual.

Procedure:

DIVERSION

1. The ED identifies that it is unable to accommodate further patient influx.
2. The charge nurse in conjunction with the ED physician contacts the ED Director/designee, who will then coordinate efforts to alleviate the situation. The Director/designee will consult with the VP of Patient Care Services and the Administrator on call as needed to get the situation relieved. If the situation is not able to be relieved, the appropriate diversion may be called at this point.
3. The department notifies the CHE House Supervisor.
4. The CHE House Supervisor pages all CHNw leadership, utilizing the network emergency alpha pagers: "Dart Meeting" with time and meeting place.
5. The DART is immediately activated, as follows (unless previously activated):
   a. There is an immediate halt on all placements of admissions, while a rapid assessment of the situation is conducted; the halt applies to, but is not limited to the following areas/departments: ED, Operating Room (OR), Post Anesthesia Care Unit (PACU), Cardiac Cath Lab, and all inpatient and short stay/daybed units.
   b. Guidelines for this rapid but thorough assessment may include, but are not limited to:
      1.) Analysis of numbers of patients throughout the facility
         b.) in ED -- total and those to be admitted
         c.) in the Cath Lab – currently and slated
         d.) the OR/PACU -- currently and slated
      2.) Assessment of number of available house beds, including pending discharges and transfers

3.) Assessment of bed utilization
   a.) Are all available beds being utilized?
   b.) Are there any beds on the Pediatric or Family Rooms units? (Note: Pediatrics can take patients up to age 25 without special permission; Family Rooms can take non-infectious female patients)
   c.) Does a unit (or units) need to "flex up"?
   d.) Can patients be held in closed areas, eg, Endoscopy or Ambulatory Care?
   e.) Can stable patients be temporarily placed in inpatient unit hallways?
   f.) What closed beds can be re-opened immediately? in one hour? in four hours?
   g.) Who else can be utilized to provide patient care - non-clinical and/or administrative nurses to provide direct patient care?

4.) Movement of patients
   a.) Has a particular patient's condition been upgraded, qualifying the patient for a lower level of care?
   b.) Can patients be transferred to another CHNw facility? (eg, cardiac patients going to CHVH the next morning for cardiac catheterization.)

6. If diversion is unavoidable, the CHE House Supervisor makes the following notifications, in this order, 24/7:
   a. Notify EMS:

CHE Hancock County – Buck and Sugar Creek	Mesh Indy TRAC System
CHN/CHVH/Behavioral Care Hamilton County	Mesh Indy TRAC System
CHS Brown Township	Mesh Indy TRAC System

   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers: "Diversion" with what hospital and pertinent information related to the diversion.
7. CHE House Supervisor will log diversion information in the Network Diversion Log.
8. The entire situation will be re-evaluated, not less than every two (2) hours.
9. The diversion will be deactivated as soon as possible; the CHE House Supervisor will:
   a. Notify EMS, following the above steps, see 6.a.
   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers stating the diversion is over.
   c. The CHE House Supervisor will log the information in the Network Diversion Log.

DECLARING A YELLOW, BLUE OR RED LIGHT BED ALERT

1. Each unit/department assesses bed availability for potential problems. Notify the House Supervisor at CHE via alpha-numeric pager 904-4110 of potential problems.
2. The CHE House Supervisor assesses daily at 0500, 1300, 2000, and PRN the number of current inpatients at all 4 Indianapolis Community Health Network hospitals
3. The CHE House Supervisor evaluates the information from all sites to determine if a Bed Alert needs to be called. The CHE House Supervisor will assess which are the most appropriate units to place centralized staff when supply and demand do not match, eg skill mix, on-call procedures.
4. When a RED LIGHT is called, departments may be notified of the potential need to hold patients.

EMERGENCY STAFFING PLAN INITIATION:

1. Department Directors or designee determine staffing requirements for providing essential patient care and services (ie Nursing Service, Dietary, Laboratory, X-ray, and Maintenance) and initiate plans, which may include:
   a. Retain current staff.
   b. Recruit staff from alternative sources within the hospital network.
   c. Request transportation service
   d. For coordination, all nursing service units/departments communicate their individual nurse staffing status with Centralized Staffing (

TRANSPORTATION SERVICES

1. Leadership arranges employee transportation with Security ( ), making the request as soon as possible but not more than three (3) hours prior to employee's scheduled start time.
2. Security determines transportation assignments, considering:
   a. Weather and road conditions.
   b. Employees located in close proximity to others may in some cases determine pick-up priorities.
3. Safety & Security coordinates requests for return transportation with pick up requests. Pick up requests have priority over return transportation. Return transportation is scheduled on a first come, first serve basis.
4. Transportation vehicle pool:
   a. All hospitals owned vehicles are available to the Transportation Pool
   b. Security Dispatch contacts the Director of Facilities Engineering or designee in regards to providing transportation assistance
   c. All drivers are issued a two – way radio or cellular phone.
   d. Security dispatch records driver mileage.
   e. Expenses (mileage) is recorded when non-hospital owned vehicles are used for the reimbursement of expenses under standard travel practices.
   f. Fuel reimbursement and hourly wages to hospital and non-hospital employees will be paid fuel reimbursement and hourly wages after receipts are turned into the Secretary of Safety and Security.

LODGING QUARTERS AND PROVISIONS:

1. If necessary, due to the projected length of severe, inclement weather or the projected length of the Internal Disaster, lodging quarters will be provided for employees who volunteer or are requested to stay in the hospital to staff projected vacancies.
2. Lodging will be coordinate by Environmental Services and House Supervisor.
3. Toiletries are coordinated through Materials Management.
4. Food services are coordinated by Nutrition and Food Services. The Cafeteria will be available during regularly scheduled meal periods.

Owned by: CHE House Supervisor

Approved by:		
	Infection Prevention	Date: 12/13
	Risk Management	Date: 12/13
	Safety and Security	Date: 12/13
	Emergency Department Directors	Date: 12/13
	Nutrition and Food Services	Date: 12/13
	Environmental Services	Date: 12/13

CNO Designee

Date: 12/13

Approved: _____

Network President/CEO

Date:

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 20

OPERATIONAL PROCESS PERFORMANCE IMPROVEMENT COMMITTEE

"20. **Operational process performance improvement committee:** There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 20 are met with a copy of Community Hospital East Trauma Program Operational Process Performance Guidelines. The Trauma Program Managers have been meeting since April 2014, and the Community East TPOPP Committee has recently started meeting early June, 2014. A small sample of meeting times and minutes is attached.

Community Hospital East
1400 Ritter Ave
Indianapolis, IN 46219
317-355-1411
www.ecommunity.com

Community Health Network

Level III Trauma Center Performance Improvement Plan Guidelines

Personnel:

Applicable to all hospital staff and Medical Staff

Philosophy:

Services by the CHE Trauma Program are of the highest quality with a focus to provide superior value to our patients.

Mission:

The Trauma Program Performance Improvement and Patient Safety Plan is designed to ensure efficient, cost effective, quality patient care that is facilitated by continuous, systematic and objective data analysis and multidisciplinary peer review to identify opportunities to improve patient safety through all phases of trauma care. The ultimate goal is to reduce mortality and morbidity in the Trauma patient population. This guideline establishes a formal, validated, internal performance improvement process that provides for a multidisciplinary approach to rapid problem identification, data-driven analysis and resolution of issues within the quality framework of our institution.

Goals:

The Trauma Services Performance Improvement Patient Safety Plan is designed to provide an ongoing, comprehensive and systematic structure for monitoring the quality and appropriateness of multidisciplinary care for the injured patient. The monitoring and evaluation of patient care is based upon predetermined standards.

These standards include the following:

1. Evidence-based practice management guidelines (EBPMGs) and guidelines developed by the Trauma Performance Improvement and Operations (PIPS and Operations) Committee.
2. Resources for Optimal Care of the Injured Patient: 2006 developed by the American College of Surgeons, Committee on Trauma.
3. The State Rules and Regulations for Trauma Centers.

The specific goals of the Trauma and PIP and Operations Plan include:

1. Regular and systematic monitoring of the process of care and outcomes for the injured patient.
2. Monitor and intervene to assure the appropriate and timely provision of care.
3. Improve the knowledge and skills of the trauma care providers.
4. Assure compliance with accrediting and regulating agencies governing the designation of trauma centers.
5. Provide the institutional culture, structure and organization to promote quality improvement.

Authority and Scope:

The Trauma Performance Improvement Program is under the direction of the Trauma Medical Director (TMD). The TMD has the express authority and duty to manage all aspects of Trauma care. The TMD has specific authority to correct trauma program and medical staff deficiencies.

Credentialing:

All physicians who participate in the care of injured patients will be credentialed according to the medical staff bylaws. The Trauma Program Manager (TPM) in collaboration with nursing leadership is responsible for overseeing the credentialing and continuing education of nurses working with trauma patients.

Patient Population:

As illustrated on the Indiana Trauma Registry Inclusion Map in **Appendix A**, the trauma patient is defined as any patient with ICD9-CM discharge diagnosis of 800.00-959.9 (ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9); excluding ICD 9-CM 905-909.9, 910-924.9 and 930-939.9. (ICD-10-CM S00, S10. S20, S30. S40, S50, S60, S70, S80, S90). The patient record must also include one of the following:

1. Any hospital admission.
2. Any trauma transfer either into or out of the hospital.
3. Any death resulting from the traumatic injury (independent of hospital admission or hospital transfer status.
4. Any trauma team activations (Code Trauma, Trauma Alert or Trauma Consult).
5. Any patient meeting inclusion criteria as designated by the NTDB.

Community East Hospital will be submitting trauma data to the National Trauma Data Bank (NTDB) once per year as designated by the NTDB.

Community Hospital East
1400 Ritter Ave
Indianapolis, IN 46219
317-355-1411
www.ecommunity.com

Community Health Network

Data Collection:

Quality review is dependent upon both concurrent and retrospective data abstraction. The data will be abstracted by the Trauma Registrar or designee from patient records meeting the patient population definition. The Trauma Program Manager will abstract ten percent of the patient population to ensure the inter-rater reliability. The data sources include but are not limited to the following:

1. Pre-hospital reports
2. Computerized hospital medical records
3. Hand-written hospital records
4. Trauma registry analysis
5. Audit filters
6. Medical examiner report review
7. Sentinel event report
8. Internal special studies conducted by the TPM
9. Special studies conducted by other disciplines or departments
10. System analysis referrals
11. Direct observation and reporting by trauma service providers or other care providers

Audit Filters:

A. The following selected outcomes will be evaluated by the Trauma Peer Review Committee.
    1. Mortality
    2. Patient with gunshot wound or stab wound which penetrates the abdominal wall which does not receive an exploratory lap if not being transferred
    3. Patient requiring laparotomy which is not performed within two hours
    4. Negative exploratory laparotomy
    5. Unplanned abdominal, thoracic, vascular or intracranial complications that occur greater than 24 hours after arrival
    6. Thoracotomy procedure performed in the ER if patient is not transferred
    7. Readmission: Patient previously an inpatient on the trauma service-discharged and is readmitted as an inpatient within 7 days of initial discharge
    8. Delay of diagnosis
    9. Patients with an interval of greater than 8 hours between arrival and treatment of open fracture or laceration into the joint if patient not transferred
    10. Missed activation with serious or potentially serious detriment to patient care
    11. Sentinel events
    12. Major complications which significantly increase length of stray or impact positive patient outcomes

13. Significant deviation from brain trauma guidelines

B. The following outcomes will be tracked for general nursing or multidisciplinary review:
    1. Under or over triage
    2. Major nursing documentation deficits or errors
    3. Fracture identified after 24 hours
    4. Glasgow Coma Scale (GCS) 8 or less which left ER without an advanced airway
    5. GCS <13 receives Head CT > two hours after arrival
    6. Massive transfusion protocol initiated
    7. Complicated intubation
    8. System issues (misplaced imaging reports, misplaced blood specimens, communication equipment failure)
    9. Activation not implemented correctly
    10. Delays in rehab disposition
    11. Patient evaluated in ER and discharged with return to hospital within 72 hours with subsequent admission
    12. Apparent inappropriate pre-hospital treatment or omission
    13. NG inserted in patient with contraindications (mid facial fractures, etc)
    14. No nutritional support within 72 hours of arrival
    15. No rehab consult prior to day of DC when needed

C. Specific audit filters
    1. No documentation of c-spine clearance
    2. Delayed or absent Venous Thromboembolism (VTE) prophylaxis when indicated
    3. Inter-facility transfers
    4. GCS not documented
    5. Missing hourly VS for code trauma activations
    6. Missing sequential GCS on head injured patients
    7. Trauma surgeon response time greater than 30 minutes of patient arrival
    8. Re-intubation within 48 hours of extubation
    9. Code Trauma remained in ER greater than two hours
    10. Code Trauma Activations discharged home from ER
    11. Transfer to Level I or II Trauma Center greater than one hour from transfer decision
    12. Transfer decision made greater than one hour from patient arrival
    13. EMS scene time greater than 20 minutes
    14. Absence of EMS Patient Care Report
    15. All trauma deaths
    16. All neurosurgical trauma cases
    17. All delays in identification of injuries

18. Indiana Blood Center response to emergency request when product delivery to CHE is greater than three (3) hours.

D. The following focused audits will be reported as follows
    1. Nursing education compliance (annually).
    2. Physician credential compliance (annually).
    3. Trauma Peer Review Committee Physician attendance (at least quarterly).
    4. Surgeon response time (at least quarterly).
    5. Data integrity validation audit (at least quarterly).
    6. Over and under triage (at least quarterly).
    7. Indiana Blood Center response (annually).
    8. Compliance with the Brain Trauma guidelines (at least quarterly).

Performance Improvement Process:

Performance improvement consists of ongoing evaluation of all facets of trauma care provided to the trauma patient. The process is illustrated in Trauma PI Flowchart in **Appendix B.** The Trauma Medical Director and Trauma Program Manager provide ongoing and systematic monitoring of care provided by medical, nursing, and ancillary personnel. Performance Improvement review consists of the utilization of pre-selected quality indicators and additional hospital and regional focused audits. In addition, a process of tracking complications, systems issues, provider issues, and adverse events is determined. The Trauma Program Manager will report all issues and opportunities for improvement to the Trauma Medical Director for determination for the need for further review via the *Trauma Peer Review Committee, Trauma Patient Improvement and Patient Safety and Operations Committee, or Quality of Care Committee.* Documentation of resolution of identified issues (loop closure) is the responsibility of the Trauma Medical Director and the Trauma Program Manager. The use of quality indicators to measure, evaluate, and improve performance is an important component of the Trauma Performance Improvement Plan.

A. First Level of Review

The Trauma Program Manager or designee will do the initial case review of all trauma patients. Appropriate clinical care without provider or system issues identified will need no further review.

B. Second Level of Review

Opportunities for improvement in the system or provider and sentinel events are referred to the Trauma Medical Director (TMD). The Trauma Medical Director and the Trauma Program Manager will perform the second level of review. Further analysis of the case and issue(s) identified will occur. Those cases in which a simple action plan, such as trending of the issue, targeted education, provider counseling or discussion is the only corrective action identified need not proceed to the next level of review. Deaths, significant adverse events and cases involving more than one service or provider

with opportunities for improvement should be elevated to the Third Level of review. Trauma PI issues will be documented on the "Event Tracking Form" in **Appendix C**. This form tracks all patient care issues, serves as a reference for PI activity, and assures proper documentation and loop closure by tracking all aspects of the case review to include:

1. Clinical Summary.
2. Trauma Medical Director review.
3. Determinations of committee.
4. Corrective actions.
5. Re-evaluation and loop closure date.

C. Third Level of Review

Tertiary Review will occur with the Trauma Peer Review Committee or the Trauma Patient Improvement and Patient Safety and Operations Committee.

D. Purpose of the Meetings

a. Process Improvement issues identified in the review that deal with the system of care in the facility are appropriate to discuss in this venue. These include issues such as:
    1. Creation of Trauma Activation Criteria
    2. Creation of pathways and protocols
    3. Process for utilizing a call team for OR cases
    4. Determination of additional requirements for service o the trauma team

These issues deal more with the system of care and not an individual provider. It is important to have representation from all hospital and pre-hospital stakeholders (representatives) at this meeting

b. Provider Peer Review-issues identified in the review that deal with specific cases and provider issues that arise. These include issues such as:
    1. Timeliness of response to a high level activation
    2. Appropriateness of evaluation and treatment
    3. Appropriateness of admission or transfer
    4. Trauma Death

c. A judgment will be rendered by the committee with regards to the appropriateness of the issue referred for further review. At the conclusion of an incident review the Trauma Peer Review Committee may take any of the following actions:
    1. Determine that care was appropriate and close the case.

2. Determine the need for intervention or corrective action and support the TMD during intervention implementation.
3. Determine the need to track and trend.

d. All mortality will be reviewed according to the following metrics:
   1. Survival with Opportunity for Improvement (OFI) in the care
   2. Unanticipated Mortality with Opportunity for Improvement (OFI)
   3. Anticipated Mortality with Opportunity for Improvement (OFI)

Further recommendations for performance improvement based on tertiary review will be made to the relevant hospital committees who with the trauma program are responsible for loop closure.

E. Performance Improvement Action Plan

All corrective action planning and implementation will be overseen by the Trauma Medical Director and Trauma Program Manager. Possible corrective actions may include:

1. Education
2. Trending of issue
3. Policy or Guideline Development/Revision
4. Counseling
5. Referral (Management, Quality, etc.)Peer Review
6. Focused Audit
7. Resource Enhancement

F. Loop Closure and Re-Evaluation

An essential component in Performance Improvement is demonstrating that a corrective action has the desired effect. The outcome of any action plan will be monitored for expected change and re-evaluated accordingly so that the PI loop can be closed. No issue will be considered as "closed" until the re-evaluation process has been complete and it demonstrates a measure of performance and sustainability that has been deemed acceptable. This evaluation usually occurs within three to six months of the corrective action. Documentation should include the following aspects of follow-up and re-evaluation:

1. Time Frame for Re-evaluation
2. Documentation of Findings
3. Results of Re-monitoring

G. Integration into the Hospital Performance Improvement Reporting Structure

Any organizational improvement activity performed by the Trauma Program Performance Improvement Committee is eligible for submission to Quality Resources for inclusion in specific reports to the Leadership, Clinical Core Groups (CCG) and/or the

Quality of Care Committee of the Board. The Quality Resources staff is available for assistance in data collection, aggregation, analysis and overall data management; comparison to internal and/or external databases, and presentation of the resulting information to applicable groups.

It is preferable to use a combination of outcome and process measures of performance, to fully evaluate the care/service of delivery systems. When rates of performance or outcome vary significantly from the expected, or when the process appears stable but an opportunity to improve the care or service is identified, the Trauma Program Manager/Trauma Medical Director may exercise various options.

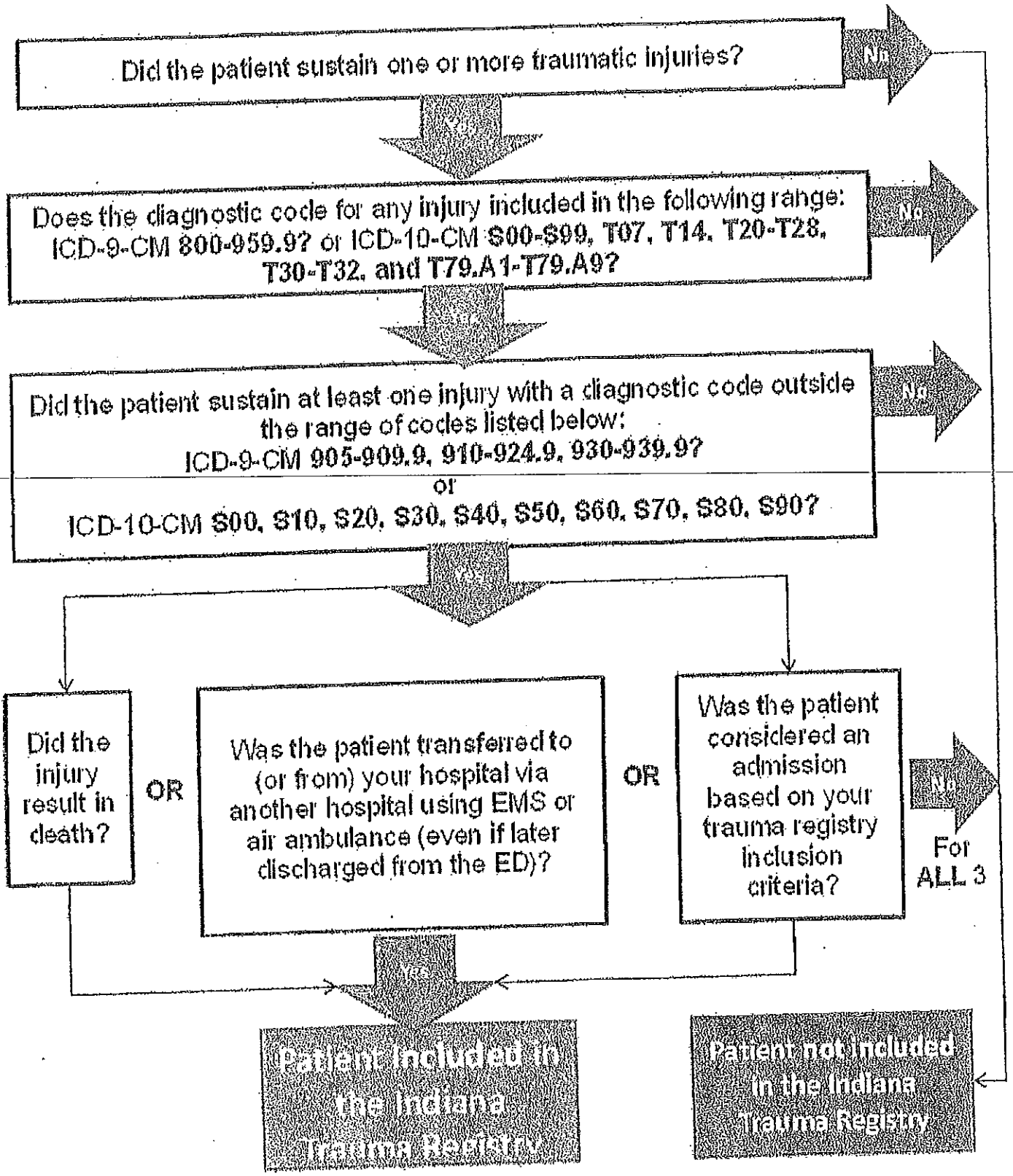
Confidentiality

All performance improvement activities that are a component of the Trauma Performance Improvement Peer Review Committee, or that are related to the treatment of specific patients are confidential. Separate records and minutes are maintained in accordance with Federal and Indiana statutes.

END

Indiana Trauma Registry Inclusion Criteria Map

APPENDIX A



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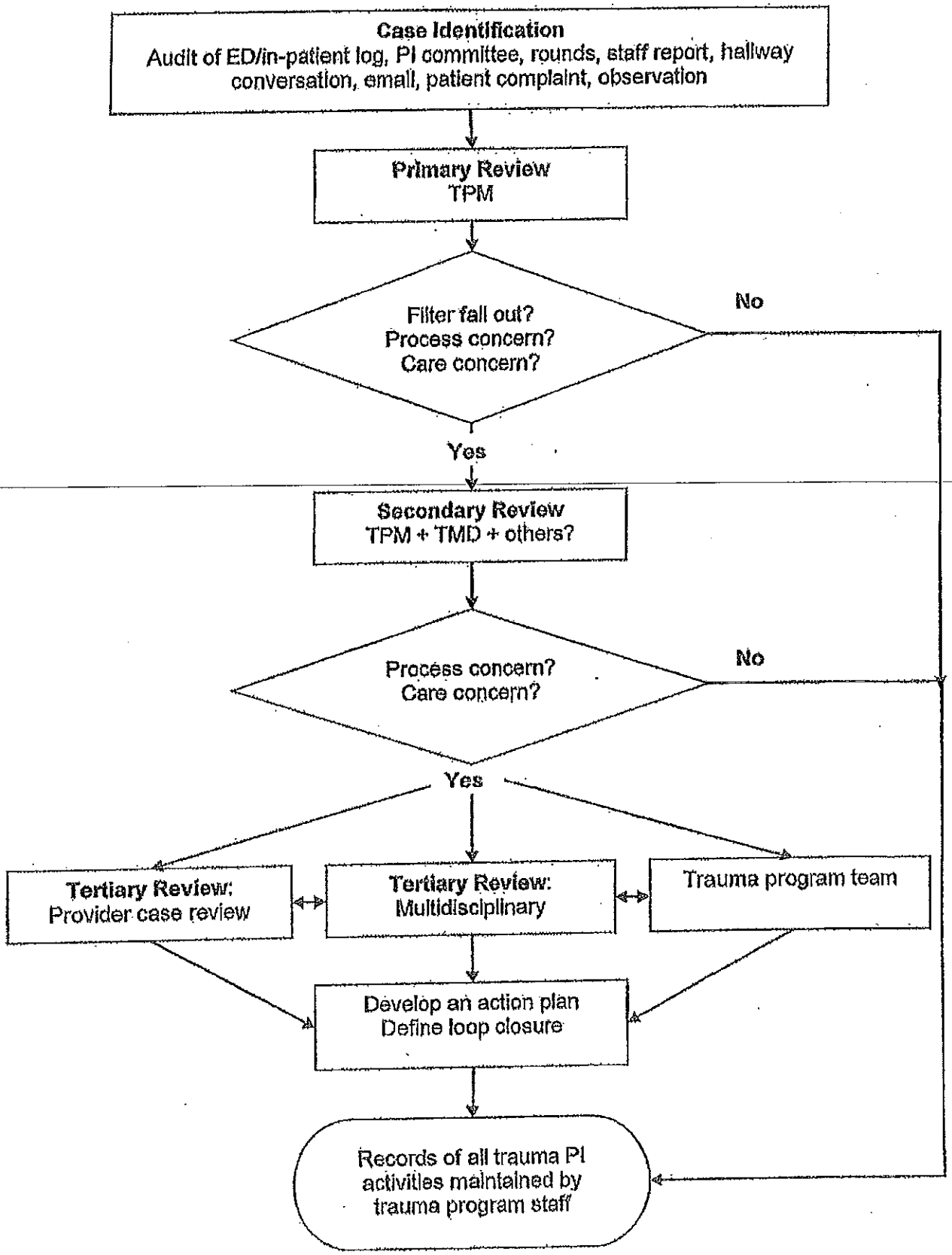
Trauma PI Flowchart



APPENDIX C

Community Hospital East
1500 North Ritter Ave
Indianapolis, IN 46219
317-355-1411

Community Health Network

Trauma Performance Improvement Review

Investigational Report

Upon identification and validation of an issue requiring attention, the patient's medical record summary will be reviewed to determine appropriateness, any variance, and whether corrective action is necessary. As part of a multi-disciplinary review process, additional services or departments may be involved. When appropriate, findings will be communicated to the hospital Risk/Quality Department.

Patient's Name/MRN# _____

Date of Evaluation _____

Review Type
- ☐ No Trauma Service Involvement
- ☐ Direct Admission
- ☐ Transfer Out
- ☐ Diversion
- ☐ Missed Activation
- Missed/Delayed Injury
- ☐ Liver/Spleen Injury
- ☐ Exploratory Laparotomy
- ☐ Autopsy
- ☐ Complaint or concern

Determination
- ☐ System-related
- ☐ Disease-related
- ☐ Provider-related
- ☐ Unable to determine
- ☐ Appropriate Management

Corrective Action
- ☐ Unnecessary
- ☐ Personal Counseling
- ☐ Trend/Monitor/Report
- ☐ Resource Enhancement
- ☐ Policy Revision/Development
- ☐ Hospital System Review
- ☐ Risk Management Review
- ☐ Peer Review
- ☐ Privilege/Credentialing Action

Comments

_____

_____

_____

_____

_____

_____

Indication of Closure
Trauma Performance Improvement Coordinator/Date _____
Trauma Medical Director/Date _____

This document represents communication to a hospital operational committee, and is therefore, privileged pursuant to Indiana Code Section 34-30-15.

COMMITTEE CHARTER

COMMITTEE NAME:	**Community East Trauma Performance Improvement and Patient Safety and Operations (TPIPS and Operations) Committee**
DATE ESTABLISHED/REVISED:	June 2, 2014
SPONSORING GROUP:	Trauma Medical Director
PURPOSE OF THE COMMITTEE IS :	To review the performance of the trauma program, review the safety of the trauma program, provide focused education, address trauma service operational issues, and ensure that the appropriate trauma patient population is identified.
The Committee Shall:	The TPIPS and Operations Committee hereby created shall meet at least quarterly. Members shall be subject to the minimum attendance requriements as specified by the American College of Surgeons. Additional meetings may be called at the discretion of the Trauma Medical Director.
Decision-making Authority:	Trauma Medical Director
Leader:	Bajhat Chabenne, M.D., Trauma Medical Director and Kristi Croddy, RN, Trauma Program Manager
Core Team:	**Trauma Medical Director** **ED Medical Director** **EMS Co-Medical Director** **Anesthesiologist** **Orthopedic Surgeon** **Neurosurgeon** **Radiologist** **ICU Medical Director** President CNO Trauma Program Manager Trauma Registrar ED Director ED Clinical Manager EMS liaison Surgery Clinical Director/Manager ICU Clinical Director/Manager PCU Clinical Manager Med Surg Nurse Manager Neuro Nurse Manger Quality Management Director Radiology Administrative Director/Manager Lab Administrative Director/Manager

Meetings: Frequency,Time and Place	**Frequency:** Weekly **Time:** 1400-1500 **Place:** Community Hospital East
Meeting Procedures:	• Standard meeting management template • Agenda distributed 24 hours in advance of meeting • Timekeeper and scribe will be notified via e-mail 24 hours in advance • Leader will collect agenda item suggestions via e-mail • Ground rules (established by group) will be observed • Decision-making by majority vote? Consensus? • Call-in option will always be provided • Leader will distribute minutes within one week of the meeting • TBD
Reporting:	Bahjat Chabenne, M.D. Trauma Medical Director
Review and Changes to Charter:	The charter shall be reviewed by the Trauma Performance Improvement and Patient Safety and Operations (TPIPS and Operations) annually. Recommended changes can be made to the leader or discussed as a group during the meeting.

Community Hospital East
TPIPS and Operations
Meeting Agenda

Date/Time: *June 2nd 1400-1500* Location: *CHE Bradley Board Room*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Sean Kennedy	ER Manager	CHE
Jim Traylor	ER Manager	CHE
Mike Kuhn	ER Director	CHE
Robin Ledyard, M.D.	Physician Liaison	CHE
Broc Hinkle	ASAP Reporting Analyst	CHE
Dina Thompson	ICU Manager	CHE
Amy Greene	PCU Manager	CHE
Kevin Harney	Neuro Manager	CHE
Leslie Hartinger	Cardiac Manager	CHE
Amy Wire	OB Director	CHE
Dorine Lewis	PACU Manager	CHE
Shelby Hurd	OR Manager	CHE
LaShauna James	Med/Surg Manager	CHE
Steve Dudley	Lab Manager	CHE
Kimacka Randle	Lab Manager	CHE
Kathy Steffen	Medical Imaging Director	CHE
Tom Jessie	Medical Imaging Manager	CHE
Kathy Bruce	ER Educator	CHE
Jenny Collins	Short Stay Manager	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	Introduced the concept that the purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to collaborate.
1405-1435 Introduction to trauma for the hospital	Powerpoint presentation on the "In the Process" Application. Discussed each element of the application, what is necessary for the application, and how each unit would be necessary in building not only the application, but also the trauma program at CHE. Gave out folders to each individual unit describing the documents needed for the "In the process" application.
1435-1445 TPIPS Introduction	Introduced TPIPS and its necessity to the trauma program. Explained the idea that as we build the trauma program, we would be inviting representatives from the units trauma touches in order to create and maintain a TPIPS committee.
1445-1500 Questions and Updates ✓ Position control	Discussed the hiring of a TMD. Currently we are in the process of naming a TMD. Explained that the future meetings would be subcommittees of the original TPIPS committee in order to work on sections of the "In the Process" application

Action Items	**Person Responsible**	**Deadline**
Education for ICU and PACU	Dina Thompson, Amy Greene, Shelby Hurd, and Dorine Lewis	June 9th, 2014

Next Meeting: June 9th, 2014

Community Hospital East
TPIPS and Operations
Meeting Agenda

Date/Time: *June 9th 1400-1500* Location: *CHE Bradley Board Room*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Sean Kennedy	ER Manager	CHE
Kathy Bruce	ER Educator	CHE
Mary Schober	Trauma Registrar	CHE and CHS
Dina Thompson	ICU Manager	CHE
Dorine Lewis	PACU Manager	CHE
Shelby Hurd	OR Manager	CHE
Paige Dooley	Admin/VP Nursing	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	Reviewed the concept that the purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to collaborate.
1405-1435 ICU	Reviewed education and policies regarding ICU related to trauma. Dina, ICU manager, wanting to know if CHE will need to write their own policies or if the network will write them as a group. Paige, CNO, wanting to know if we can create guidelines rather than writing policies.
1435-1445 PACU	Dorine relating concerns regarding staffing ratios, stating they just don't have the volume of nurses for what is required by ACS. Dorine states PACU have their own policies related to call and staffing in place and will provide them to us.
1445-1500 OR	Shelby states he has all of his documentation except for Scope of Service and states he will get them to us ASAP.
1500-1505 Misc	Paige wants to make certain resource team understands the education requirements for trauma.

Action Items	Person Responsible	Deadline
Guidelines versus Policies	Kristi Croddy and Sean Kennedy	June 16, 2014
Check with resource team to make certain they understand the requirements for trauma	Kristi Croddy	June 16, 2014
Documentation for trauma	Shelby, Dina, and Dorine	June 16, 2014

Next Meeting: June 16th, 2014

Community Hospital East
TPIPS and Operations
Meeting Agenda

Date/Time: *June 16th 1400-1500* Location: *CHE Medical Conference Room*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Sean Kennedy	ER Manager	CHE
Kathy Bruce	ER Educator	CHE
Mary Schober	Trauma Registrar	CHE and CHS
Dina Thompson	ICU Manager	CHE
Amy Greene	PCU Manager	CHE
Greg Steffen	Clinical Education	CHE
Dawn Sullivan-Wright	Clinical Education/ER Clin Spec	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	Reviewed the concept that the purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to collaborate.
1405-1435 ICU/PCU	Discussed the four hours of mandatory yearly education required. Should we build our own four hour program? Make it accommodating to everyone's schedule and have different ways to present the education. Ex. Visual, online, and in person presentations..
	Dina stated she would like to compare last year's education to new trauma education guidelines to see if they are comparable. Dina will also provide to Kristi a list of new hire orientation packet for new hires. Discussed ECCO for ICU. Dina states all new employees who do not have recent ICU experience receive ECCO.
	Kristi is going to put together a presentation on shock/trauma for CEU's for ICU/PCU staff meeting in September. In the mean-time, Kristi will do a presentation on trauma to the staff meeting in July.
	ICU will plan to put together a presentation on ICP for ED staff for CEU's to be done at a near-future staff meeting.

Action Items	Person Responsible	Deadline
Shock presentation to be given to Greg for CEU's	Kristi Croddy	July 16th
Kristi to give trauma presentation to ICU/PCU staff meeting	Kristi Croddy	July, 2014
ICU to give ICP presentation to ED at staff meeting	Dina/Amy/Alice	TBD

Next Meeting: June 23rd, 2014

COMMITTEE CHARTER

COMMITTEE NAME:	**Network Trauma Program Committee**
DATE ESTABLISHED/REVISED:	April 29, 2014
SPONSORING GROUP:	Ron (Myron) Lewis, Project Champion
PURPOSE OF THE COMMITTEE IS :	To support the provision of optimal care to the injured patient throughout the continuum of trauma care from prevention through rehabilitation, consistent with the mission of Community Health Network to obtain verification by the American College of Surgeons Committee on Trauma as a Level III Trauma Center.
The Committee Shall:	• *Trauma Program Operations*: Design process, tools, and data that will influence optimal reporting in accordance with accepted standards. • *Performance Improvement Patient Safety Program*: Review important elements of a successful PI plan, valuable audit filters, and ACS-COT expectations. • *Trauma Outreach & Education*: Best practice recommendations for trauma outreach and education, taking advantage of and sharing network resources. • *Indiana Trauma System*: Integration opportunities, and the components of a statewide trauma system. • *Trauma Program Manager*: Roles and responsibilities. • *Trauma Registry*: A trauma program cannot improve what it cannot measure, and it cannot measure without good data. • *Trauma Verification*: Planning and preparation for trauma center verification/ designation to include mock site survey visits. • *"In the Process" Application*: Assist with completion of the Indiana "In the Process" Application for Level III Trauma Center Status. • *Collaboration*: Review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to better collaborate as a team. • TBD
Decision-making Authority:	Executive Oversight Committee
Leader:	Sean Kennedy, Emergency Department Nurse Manager, Community Hospital East
Core Team:	Kristi Croddy, Trauma Program Manager, Community Hospital East Karen Hagen, Trauma Program Manager, Community Hospital North Doug McGee, Trauma Program Manager, Community Hospital Anderson Tina Sency, Trauma Program Manager, Community Howard Shawna Thomas, ED Director, Community Hospital South Broc Hinkle, ASAP Reporting Analyst, Community Health Network TBD
Meetings: Frequency,Time and Place	**Frequency:** Bi-weekly **Time:** 1400-1500 **Place:** Community Hospital North

Meeting Procedures:	• Standard meeting management template • Agenda distributed 24 hours in advance of meeting • Timekeeper and scribe will be notified via e-mail 24 hours in advance • Leader will collect agenda item suggestions via e-mail • Ground rules (established by group) will be observed • Decision-making by majority vote? Consensus? • Call-in option will always be provided • Leader will distribute minutes within one week of the meeting • TBD
Reporting:	Ron (Myron) Lewis, Project Champion
Review and Changes to Charter:	The charter shall be reviewed by the Network Trauma Program Committee annually. Recommended changes can be made to the leader or discussed as a group during the meeting.

Community Health Network
Trauma Program Manager Team
Meeting Agenda

Date/Time: *April 29, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Tina Sency	Trauma Program Manager	Community Howard
Shawna Thomas (phone)	ED Director	CHS
Sean Kennedy	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1410 Meeting Objective/Goals	As we continue the pursuit of trauma verification, organization, consistency, and teamwork are all critical to success, not just at the individual sites, but for the entire network. The purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, through an organized approach responsive to the team. The meetings will also serve to enhance communication and opportunities for collaboration.
1410-1420 Long/Short Range Planning ✓ Project Timeline	Please see the attached graphic outlining the CHNw Trauma Verification Timeline.
1420-1440 Hot Topics/Progress Updates ✓ Trauma Registry Software ✓ Trauma Education ✓ Role Hiring ✓ Transfer Agreements ✓ Successes & Barriers	*Trauma Registry Software*: The network has decided to purchase the upgraded version of ImageTrend. In the meantime and in anticipation of the May 17th deadline, please utilize the free state product to submit data. While we still need to identify how each program will capture trauma patients who do not meet predetermined activation criteria immediately upon arrival, a canned report will greatly assist our Trauma Registrars to quickly collect data. The Indiana Trauma Registry requires the NTDB data elements for each incident submitted. Thank you to Broc and Judy for your efforts thus far. As a reminder, please see the attached list. *Trauma Education*: In an effort to meet the growing needs of our network, CHN will host a TNCC course June 5-6 and June 25-26. Also, if you haven't attended already, please consider the Trauma Program Manager Course. http://www.amtrauma.org/courses/councils/trauma-coordinator-course2/index.aspx *Role Hiring*: All sites have hired a Trauma Registrar, except CHE and CHS who are in the process of interviewing. CHA is the only site with a confirmed Trauma

	Medical Director. According to the ACS, the TMD must be a general surgeon who is "active at the facility and should have some dedicated/protected time devoted to his/her role as the TMD." Again, not every trauma case requires activation. Ideally only the highest level of activations will require a 30-minute response time from the general surgeons. Depending on the facility, the volume will not be that high. The specific criteria must be agreed upon by the Trauma Medical Director. In the meantime, as a team, we will draft a tiered-trauma activation system. *Transfer Agreements*: Shawna and Ron are in the process of completing Transfer Agreements with Eskenazi, IU Health Methodist, and Riley for each location.
1440-1450 Trauma System Integration ✓ ISTCC/ITN: *May 9, 1000-1400* ✓ IPAC: *June 12, 1300-1500* ✓ Indiana Trauma Registry: *TBD*	Integration into the statewide trauma system is vital to learn, network, and advocate. Please see the upcoming opportunities, and make an effort to attend via phone or in person. If you cannot join us this Friday, I will report back to the group at our next meeting.
1450-1455 *Orange Book* Pre-Publication Review Workshop	As a team, we will review this publication, chapter by chapter, at the bi-weekly Trauma Program Manager Meetings to ensure our programs are organized, consistent, and compliant. The team was asked to review Chapter 1 in advance of our next meeting so that we can discuss relevant items together.
1455-1500 Open Forum	If you haven't already, I encourage you to print a copy of the Orange Book provided as pdf. The ACS has not yet confirmed if and when it will be in print.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 1 of *Orange Book*	Trauma Program Managers	May 13, 2014
Complete Gap Analysis Tool	Trauma Program Managers	May 13, 2014
Draft Trauma Activation Criteria	Sean Kennedy, Doug McGee, Karen Hagen	May 13, 2014

References: Indiana "In the Process" Application for Level III Trauma Center, Resources for Optimal Care of the Injured Patient

Next Meeting: May 13, 2014

Community Health Network
Trauma Program Manager Team
Meeting Agenda

Date/Time: *May 13, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Tina Sency	Trauma Program Manager	Community Howard
Amanda Gonzalez (phone)	ED Manager	CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHE
Sean Kennedy	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	Restated the purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to collaborate.
1405-1415 State Trauma System Integration ✓ Indiana State Trauma Care Committee: *May 9 meeting update* ✓ Indiana Trauma Network: *May 9 meeting update* ✓ IPAC: *June 12, 1300-1500* ✓ Trauma Registry & PI Subcommittees: *TBD*	Please see the attached meeting agenda and prior meeting minutes provided at the ISTCC Meeting on May 9th. Please see the upcoming opportunities, and make an effort to attend via phone or in person. Connected the purpose and value of trauma program integration to the Criterion Deficiencies outlined in Chapter 1 of the *Orange Book.*
1415-1425 Trauma Program Status Updates ✓ Gap Analysis Tool Review ✓ Successes & Barriers	Discussed Element #1 on the *Indiana "In the Process" Application*- the Trauma Medical Director. According to the ACS-COT, "the TMD must be a board certified general surgeon and as you stated many have gone on to specialize in other areas such as cardiac, thoracic surgery, colon & rectal, bariatric, etc." These "surgeons may serve in the role of the TMD as long as they have additional expertise in trauma and care for trauma patients. Expertise define/includes trauma related CME, membership to a trauma Regional or National organization, etc al – the requirements can be found in Chapter 5 of the 2014 Resources manual." Furthermore, "the trauma surgeons on the call must meet the same requirements as the TMD above. They cannot solely perform general surgery, often time, they will do general surgery and trauma. If this is the case, there must be a backup schedule in case he/she is in the OR with a general surgery patient, when a trauma patient arrives."
1425-1440 Hot Topics/ Progress Updates ✓ Trauma Registry Software ✓ Data Submission Deadline ✓ Transfer Agreements ✓ Trauma Activation Criteria	*Trauma Registry Software*: The network has decided to purchase the upgraded version of ImageTrend. Awaiting further updates. *Submission Deadline:* In the meantime and in anticipation of the May 17th deadline to begin data

✓ Trauma Education ✓ Position Control	submission, please utilize the free state product to submit data. *Transfer Agreements*: The network is in the process of completing Transfer Agreements with Eskenazi, IU Health Methodist, and Riley for each location. No further updates. *Trauma Activation Criteria:* We reviewed and compared several local examples of trauma activation criteria, all confirmed to be based on the Field Triage Decision Scheme. As a group, we agreed consistency and standardization is imperative. As a result, the Trauma Program Manager Team is fully supportive of adopting Community Anderson's criteria for the network so that we speak the same language, operate within a similar framework, allow for accurate benchmarking, and easily communicate with EMS. *Trauma Education:* CHN will host a TNCC course June 5-6 and June 25-26. Also, if you haven't attended already, please consider the Trauma Program Manager Course and a Trauma Registrar Course. Lastly, Eskenazi Health may offer an ATLS Course in the coming months to support the need for Trauma Medical Directors and Emergency Physicians to attend prior to submission. *Position Control:* All sites have hired a Trauma Registrar, except CHE/CHS who are in the process of interviewing. CHA is the only site with a confirmed Trauma Medical Director.
1440-1450 *Orange Book* Review Workshop ✓ Pre-publication, Chapter 1	As a team, we reviewed Chapter 1 to ensure our programs understand and are in compliance. Specifically, we discussed CD 1-1, CD 1-2, and CD 1-3.
1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	Discussed the inevitable challenge of determining which patients qualify for the Trauma Registry. While ISDH and NTDB provide clear direction, it is recommended that each patient in contact with the Trauma Service is included. Doing so allows and prevents missing valuable opportunities for performance improvement, education, and injury prevention activities.
1455-1500 Open Forum	Congratulations to Community Anderson for receiving the recommendation from the Indiana State Trauma Care Committee to advance their application to the EMS Commission, which will reconvene June 20th in Gary, IN.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 2-3 of *Orange Book*	Trauma Program Managers	May 27, 2014
Complete Gap Analysis Tool, and offer to your supervisor	Trauma Program Managers	May 27, 2014
Share one success and one barrier with the group	Trauma Program Managers	May 27, 2014

Next Meeting: May 27, 2014

Community Health Network
Network Trauma Program Team
Meeting Agenda

Date/Time: *May 27, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Mary Schober	Trauma Registrar	CHE/CHS
Shawna Thomas (phone)	ED Manager	CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHE
Sean Kennedy	ED Manager/Facilitator	CHE
Tina Sency (Absent due to Board of Health)	Trauma Program Manager	Community Howard

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	The purpose of these meetings is to review and work through the core concepts of building a successful trauma program, to enhance communication, and to identify opportunities for collaboration.
1405-1410 Committee Charter ✓ Review, editions, and approval	The attached Committee Charter was provided in advance for review. I need your feedback before final approval. For instance, I propose we invite the Trauma Registrars to these meetings as their input, involvement, and collaboration is critical. If agreed, I need the names for each site.
1410-1420 IN "In the Process" Application Status ✓ Successes & Barriers	Each site provided an update, sharing challenges and successes. CHE and CHS plan to have Q2 2014 data submitted by June 1st.
1420-1435 Hot Topics/ Progress Updates ✓ Position Control ✓ Data Submission ✓ ImageTrend Software ✓ Transfer Agreements ✓ Letters of Commitment ✓ Blood Bank requirement ✓ Trauma Education	*Position Control:* All sites have confirmed a Trauma Registrar and Trauma Program Manager. With the exception of CHE, all sites have also hired a Trauma Medical Director. *Submission Deadline:* In the meantime and in anticipation of the data submission deadline, please utilize the free state product to submit data. *Trauma Registry Software*: Shawna explained the ImageTrend software will be purchased pending the establishment of a Trauma Admin Cost Center and final negotiations. *Transfer Agreements*: CHNw Legal Department has signed Transfer Agreements for Eskenazi and IU Health Methodis & Riley. More to follow. *Letters of Commitment*: A Letter of Commitment has been drafted for the Board of Directors to be submitted with the Indiana "In the Process" Application. To be uniform and consistent, a draft copy is attached for use as a template. *Blood Bank requirement*: According to the 2014 Resources for Optimal Care of the Injured Patient pre-publication: "The blood bank must be capable of blood typing and cross-matching (CD 11–81)." Moreover, "In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83)." However, ISDH has increased the requirement for Level III Trauma Centers, stating "A blood bank must be available 24

	hours per day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients." *Trauma Education:* Each Trauma Registrar is required to show evidence of at least 4 hours continuing education. For consideration, the American Trauma Society offers an online course. Aside from Community Howard and CHE, each Trauma Surgeon is scheduled to attend ATLS. Lastly, TNCC will be offered June 5-6 and June 25-26. *Position Control:* All sites have confirmed a Trauma Registrar and Trauma Program Manager. With the exception of CHE, all sites have also hired a Trauma Medical Director.
1435-1440 State Trauma System Integration ✓ Eskenazi collaboration	Following a meeting with the Eskenazi Trauma Program on May 19th, the group agreed future collaboration is valued, from serving as a resource to providing educational opportunities.
1440-1450 *Orange Book* Review ✓ Pre-publication, Chapters 2-3	Please let me know if you have any questions or concerns with the following requirements outlined in Chapters 2 & 3. It is critical that we all have a shared understanding and working knowledge of each criterion deficiency to be successful. • Surgical commitment is essential for a properly functioning trauma center (CD 2–2). • This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2–1). • Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2–3). • Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2–5). • For Level III trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the surgeon's presence is in compliance at least 80 percent of the time (CD 2–8). • A Level III trauma center must have continuous general surgical coverage (CD 2–12). • Well-defined transfer plans are essential (CD 2–13). • For Level I, II, III and IV trauma centers a trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. (CD 2-17). • Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).

	• Level I, II, III and IV trauma centers a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19). • Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22). • Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2–23). • For adult trauma centers annually admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals, however, must review the care of their injured children through their PIPS program (CD 2–25). • The trauma director must be involved in the development of the trauma center's bypass (diversion) protocol (CD 3–4). • The trauma surgeon must be involved in the decision regarding bypass (diversion) each time the center goes on bypass (CD 3–5). • The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2). • The trauma program must participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs (CD 3–1). • The trauma center must not be on bypass (diversion) more than 5 percent of the time (CD 3–6). • When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: Prearrange alternative destinations with transfer agreements in place, Notify other centers of divert or advisory status, Maintain a divert log, Subject all diverts and advisories to performance improvement procedures • Rigorous multidisciplinary performance improvement is essential to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage (CD 3–3).
1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	As described by the ACS-COT, "there is no precise prescription for trauma performance improvement and patient safety (TPIPS)." Still, the concept of monitoring, evaluating, and improving the performance of a trauma program is critical. Part of demonstrating a continuous process of monitoring, assessment, and management directed at improving care requires regular engagement of a multi-disciplinary team. *TPIPS & Operations Meeting* To address trauma program operational events, a multidisciplinary trauma systems/operations committee is necessary to examine trauma-related hospital operations. This committee should meet at least quarterly but may need to meet as often as monthly to review operational performance events. The committee should include representatives from all phases of care provided to injured patients to include: • Trauma Program Personnel, Trauma Surgeons,

	Physician representation from each service, Nursing Directors/Managers, Operating Room and PACU, Lab and Blood Bank, Radiology, Epic Team, EMS, Patient Access, Radiology, Pharmacy, EVS, Chaplain, Rehabilitation, Marketing, Executive Leadership *Trauma Peer Review Committee* In addition, regular Peer Review Committee Meetings are required. Chaired by the TMD, physician liaisons to the trauma program representing general surgery, emergency medicine, orthopaedics, anesthesiology, and critical care must be identified and "participate actively in the trauma PIPS program with at least 50 % attendance at multidisciplinary trauma peer review committee meetings." Level III centers with any number of emergent neurosurgical cases must also have the participation of neurosurgery on the multidisciplinary trauma peer review committee. All trauma deaths and unexpected outcomes should be reviewed to filter cases that need to undergo additional examination, review, discussion, intervention, and loop closure. The mortality and morbidity review often feeds cases to the multidisciplinary Trauma Peer Review committee. It is my recommendation that these meetings are combined for a Level III Trauma Center. For instance, the first half of these meetings may focus on TPIPS and Operations, while the second half can be reserved for select personnel in a confidential setting for Trauma Peer Review.
1455-1500 Open Forum	

Action Items	**Person Responsible**	**Deadline**
Review Chapter 3-4 of *Orange Book*	Trauma Program Managers	June 10, 2014
Inquire with ISDH whether proof of educational preparation for the TPM and Registrar is required for the "In the Process" Application.	Sean Kennedy	June 10, 2014
Share 1 success and 1 challenge with the group	Trauma Program Managers	June 10, 2014

Next Meeting: June 10, 2014

Community Health Network
Network Trauma Program Team
Meeting Minutes

Date/Time: June 10, *2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy (phone)	Trauma Program Manager	CHE
Lori Gill (phone)	RN	CHS
Karen Hagen (phone)	Trauma Program Manager	CHN
Judy Hall (phone)	ED Director	CHN
Mary Schober (phone)	Trauma Registrar	CHE/CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHNw
Sean Kennedy (phone)	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	To review and work through the core concepts of building a successful trauma program, to enhance communication, and to identify opportunities for collaboration.
1405-1410 Committee Charter ✓ Review, editions, and approval	The attached Committee Charter was provided in advance for review. Trauma Registrars were added to the Charter as their input, involvement, and collaboration is critical. Pending completion of the network trauma team, the charter will be submitted as final.
1410-1420 Indiana "In the Process" Application Status ✓ Gap Analysis Tool Review ✓ Successes & Barriers	The purpose of TPIPS (Trauma Process Improvement and Patient Safety) is to address trauma program operational events, a multidisciplinary trauma systems/operations committee is necessary to examine trauma-related hospital operations. This committee should meet at least quarterly but may need to meet as often as monthly to review operational performance events. The committee should include representatives from all phases of care provided to injured patients to include: o Trauma Program Staff, Trauma Surgeons, Physician Liaison from each service, Nursing Directors/Managers, Operating Room and PACU, Lab and Blood Bank, Radiology, Epic Team, EMS, Patient Access, Radiology, Pharmacy, EVS, Chaplain, Rehabilitation, Marketing, Executive Leadership The concept of monitoring, evaluating, and improving the performance of a trauma program is critical. Part of demonstrating a continuous process of monitoring, assessment, and management directed at improving care requires regular engagement of a multi-disciplinary team and evidence of such. If you haven't already, please begin organizing regular meetings with key stakeholders. Through meeting minutes and process improvement initiatives, track evidence of establishing this foundation and your plan moving forward.
1420-1435 Hot Topics/ Progress Updates ✓ Position Control ✓ Data Submission Deadline	Position Control: All sites have confirmed a Trauma Registrar and Trauma Medical Director. Aside from CHN, all sites

✓ Trauma Registry Software ✓ Trauma Activation Criteria ✓ Transfer Agreements ✓ Letters of Commitment ✓ Blood Bank requirement ✓ Trauma Flow Sheet ✓ Trauma Education ✓ Tracking TMD hours	have established a permanent Trauma Program Manager. Trauma Registry Software: CHNw is in the process of purchasing ImageTrend software. Upon finalizing, full implementation of the web-based product will take approximately 30 days. Submission Deadline: In the meantime, all sites represented on the conference call plan to submit Q1 2014 data through ImageTrend by the June 30th deadline. Trauma Activation Criteria: There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program. CHE has drafted a policy to share with network Trauma Program/ED leadership, provide to the Trauma Medical Directors for review, and have presented at the next Med Exec Committee for approval. Transfer Agreements: CHNw Legal Department has signed Transfer Agreements for Eskenazi and IU Health Methodist & Riley. More to follow once finalized. Letters of Commitment: A Letter of Commitment template with CHNw letterhead was provided for the Indiana "In the Process" Application to promote uniformity. Some facilities have elected to use facility-specific letterhead. Blood Bank requirement: "In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83)." However, ISDH has increased the requirement for Level III Trauma Centers, stating "A blood bank must be available 24 hours per day with the ability to type and crossmatch blood products, with adequate amounts of PRBCs, FFP, platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients." MACL has provided CHE a Letter of Commitment, product inventory, and other materials needed for the application. Please let me know if your site has not received this information. Trauma Flow Sheet: Upon arrival and during the initial acute resuscitation phase, nursing will need to have available a hard copy form to capture patient information. Considering we do not currently have access to Trauma Narrator in Epic, the Trauma Program/ED leadership will draft a Trauma Flow Sheet to present for adoption by Emergency Departments. In the meantime, Broc Hinkle will investigate integration. Trauma Education: Each Trauma Registrar is required to show evidence of at least 4 hours continuing education. For consideration, the American Trauma Society offers an online course of which the CHE TPM and Registrar will take. Aside from Community Howard, each Trauma Surgeon is confirmed to attend ATLS. Lastly, TNCC was offered to network employees June 5-6, and is scheduled again June 25-26. Tracking TMD hours: CHE leadership has asked that the Trauma Program Manager develop a system to track and report administrative hours of the Trauma Medical Director each month, distinguishing time dedicated to chart reviews,

	policy development, meeting attendance, etc. It is recommended each site considers adopting a similar process.
1435-1440 State Trauma System Integration ✓ Indiana State Trauma Care Committee ✓ Indiana Trauma Network ✓ Indiana Prevention Advisory Council ✓ Trauma Registry & PI Subcoms	The next Indiana State Trauma Care Committee and Indiana Trauma Network meetings are schedule August 8th at the ISDH. I encourage you all to attend, but will at the very least share updates and meeting minutes with the group. The next IPAC meeting is scheduled September 10 from 1000-1200 at ISDH.
1440-1450 *Orange Book* Review Workshop ✓ Pre-publication, Chapters 4 & 5	Chapter 4: Interhospital Transfer • Direct physician-to-physician contact is essential (CD 4–1). • The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network (for example, a health maintenance organization or a preferred provider organization) or the patient's ability to pay (CD 4–2). • A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3). • Perform a PIPS review of all transfers (CD 4–3). Chapter 5: Hospital Organization and the Trauma Program • A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff (CD 5–1). • Documentation of administrative commitment is required from the governing body and the medical staff (CD 5–1) • This support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–2). • The support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–3). • The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (CD 5–4). • The TMD must be a current board-certified general surgeon (or a general surgeon eligible for certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and must participate in trauma call (CD 5-5). • The TMD must be current in Advanced Trauma Life Support® (ATLS®) (CD 5–6). • The TMD, in collaboration with the TPM, must have the authority to correct deficiencies in trauma care and exclude from trauma call the trauma team members who do not meet specified criteria (CD 5-11). • The TMD's responsibility extends far beyond the

	technical skills of surgery. The TMD must have the authority to manage all aspects of trauma care (CD 5–9). • The TMD must chair and attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. (CD 5-10) • In addition, the TMD must perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5-11). • The TMD must have the responsibility and authority to ensure compliance with the above requirements and cannot direct more than one trauma center (CD 5-12). • The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13). • Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team. • In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15). • At a minimum, the ACS requires the six criteria listed in Table 2 to be included in the highest level of activation in all trauma centers (CD 5–13). • Again, the six criteria listed in Table 2 must remain in the highest level of activation (CD 5–13). • The emergency physician may initially evaluate the limited-tier trauma patient, but the center must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission (CD 5-17). • Programs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS process (CD 5–18). • In Level III centers, injured patients may be admitted to individual surgeons, but the structure of the program must allow the trauma director to have oversight authority for the care of these patients. (CD 5-17) • There must be a method to identify the injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners (CD 5–21). • In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients (CD 5-22). • The trauma center's PIPS program must have a multidisciplinary trauma peer review committee chaired by the TMD (CD 5-25).

1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	According to the ACS-COT, "Nurses and other allied health professionals should receive initial and recurrent trauma-specific education to ensure a high level of competency. Additional levels of training and certification should be available to nurses working in critical areas such as the emergency department and the trauma intensive care unit. In the Level III trauma center, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care." At a previous facility, we provided several, inexpensive opportunities for CE-approved education. For instance, rather than creating a new policy or practice guideline for each nursing unit, we met the requirements of a facility-based Trauma Education Plan by creating an educational grid reflecting each unit's expectation for trauma education. From establishment of a *Trauma Lecture Series* to monthly *Multi-disciplinary Case Conference*, we were able to support this requirement. In the future, as a network, we should consider development of a home-grown Trauma Orientation Course, providing a common framework from which we all operated. We armed staff with an understanding of the unique pathophysiology of trauma, network protocols and resources, and equipment used to care for the injured patient.
1455-1500 Open Forum	Welcome to the team Roxann Kondrat. We are excited to have you with us, and look forward to meeting you.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 6 & 7 of *Orange Book*	Trauma Program Managers	June 24, 2014
Update Gap Analysis Tool	Trauma Program Managers	June 24, 2014
Share one success and one barrier with the group	Trauma Program Managers	June 24, 2014

Next Meeting: June 24, 2014

Community Health Network
Network Trauma Program Team
Meeting Agenda

Date/Time: June 13, 2014/ 1200-1300 Location: CHE Medical Staff Conference Room

Attendance:

Name	Title	Location
Sean Kennedy	ED Manager	CHE
Kristi Croddy	TPM	CHE
Judy Hall	ED Director	CHN
Karen Hagen	TPM	CHN
Shawna Thomas	ED Director	CHS
Roxann Kondrat	TPM	CHS
Mike Kuhn	ED Director	CHE
Ron Lewis (phone)	Interim President & CEO	CHRH

Agenda Items	Discussion
1200-1205 Meeting Objective/Goals	As the network pursues trauma verification, each site will be presented unique opportunities. However, an objective shared by all is the establishment of guidelines centered on care of the injured patient. A key component of an effective trauma program (and one that is required for submission with the Indiana "In the Process" Application), the development of key guidelines is necessary prior to July 8th.
1205-1220 Tiered Activation Guideline • Tiered Activation System: There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program.	Kristi presented a draft Trauma Tiered Activation Guideline, based upon best practice from University of Cincinnati, St. Vincent, and Community Anderson. As a group, we agreed to a tiered activation system with "Code Trauma" representing the highest level activation and "Trauma Alert" as the second level activation. Following revision of the document, Kristi will redistribute for final review prior to sharing with the Trauma Medical Directors for approval.
1220-1235 Trauma Transfer Guideline • Transfer agreements and criteria: The hospital must include as part of its application a copy of its transfer criteria specific to trauma patients, and copies of its transfer agreements. • The trauma patient transfer guideline should include, at the minimum, the criteria outlined by the ACS-COT.	As CLN-2031 already addresses the CHNw Transfer Policy, creation of an additional policy is not necessary. Instead, Shawna will provide the group a draft Trauma Transfer Guideline for review prior to sharing with the Trauma Medical Directors for approval. The guideline will meet the requirements outlined by the ACS-COT.
1235-1245 Nurse Credentialing Requirements • "Nurses and other allied health professionals should receive initial and recurrent trauma-specific education to ensure a high level of competency. Additional levels of training and certification should be available to nurses working in critical areas such as the emergency department and the trauma intensive care unit. In the Level III trauma center, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care."	Rather than creating a new policy or practice guideline for each nursing unit, the requirements of a facility-based Trauma Education Plan can be met by establishing an education grid (much like the Chest Pain or Stroke Certification Process). Sean shared a draft guideline, published by each Trauma Program and mandated for staff who care for the injured patient. Following revision of the document, Sean will redistribute for final review, presentation, and adoption.

1245-1255 Trauma Flow Sheet • Upon arrival and during the initial acute resuscitation phase, nursing will need to have available a hard copy form to document patient information.	After reviewing Trauma Flow Sheet examples from Eskenazi, St. Vincent, and Community Anderson, the group agreed to design a document based upon Eskenazi's template. Shawna will ask her Administrative Assistant to draft an example to share with the group for approval.
1255-1300 Open Forum	*Policy creation is time and resource-intensive. As a group, we agreed it is not prudent, nor necessary to engage. Instead, "operational guidelines" were proposed, assuring needed direction while allowing for flexibility. *Please submit all deliverables by Tuesday, June 17th to review and share with the Trauma Medical Directors. *The group will reconvene next week on Friday, June 20th from 1400-1500.

Community Health Network
Network Trauma Program Team
Meeting Agenda

Date/Time: *June 24th, 2014 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy (Absent)	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Mary Schober (Absent)	Trauma Registrar	CHE/CHS
Roxann Kondrat	Trauma Program Manager	CHS
Broc Hinkle (Absent)	ASAP Reporting Analyst	CHE
Sean Kennedy (Absent)	ED Manager/Facilitator	CHE
Tina Sency (Absent)	Trauma Program Manager	Community Howard

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	The purpose of these meetings is to review and work through the core concepts of building a successful trauma program, to enhance communication, and to identify opportunities for collaboration.
1405-1410 Indiana "In the Process" Application Status ✓ Gap Analysis Tool Review ✓ Successes & Barriers	All sites are prepared to turn in application for review by the ISTCC by July 8th. Drafts are due Friday June 27th, 2014 to submit to Anne Pak with the Copy Center.
1410-1435 Hot Topics/ Progress Updates ✓ Position Control ✓ Data Submission Deadline ✓ Trauma Registry Software ✓ Transfer Agreements ✓ Letters of Commitment ✓ Blood Bank requirement ✓ Trauma Flow Sheet ✓ Trauma Education Tracking TMD hours	Position Control: o CHE: TMD, TPM, Registrar o CHN: TMD, Interim TPM, Registrar o CHS: TMD, TPM, Registrar o CHA: TMD, TPM, Registrar o CHRH: TPM, Registrar Submission Deadline: CHE, CHS, CHN plan to submit "In the Process" Application by July 8th. Transfer Agreements: IU Health is complete, Eskenazi is pending. Upon receipt, will be distributed to all. Blood Bank requirement: MACL has provided a Letter of Commitment to North, East, and South, product inventory, and other materials needed for the application. Please let me know if your site has not received this information. Trauma Flow Sheet: After reviewing Trauma Flow Sheet examples from Eskenazi, St. Vincent, and Community Anderson, the group agreed to design a document based upon Eskenazi's template. Flow sheet was reviewed by those present and Roxann will draft changes made and send to all for final approval. Trauma Education: Each Trauma Registrar is required to show evidence of at least 4 hours continuing education. The American Trauma Society offers an online course which the CHE Registrar and the CHN Registrar are registered for. The

	East TPM and the South Registrar are planning on taking. Roxann is also attempting to contact ATS regarding getting a Trauma Program Manager Course set up in the Indianapolis area for all TPMs to take. Lastly, TNCC was offered to network employees June 5-6, and is scheduled again for June 25-26. Tracking TMD hours: CHE leadership has asked that the Trauma Program Manager develop a system to track and report administrative hours of the Trauma Medical Director each month. North and South have spoken to their Trauma Medical Directors regarding tracking their hours.
1435-1455 *Operational Guideline* development ✓ Trauma Tiered Activation Guideline ✓ Trauma Transfer Guideline ✓ Nurse Credentialing Requirements	Trauma Tiered Activation Guideline: All present have reviewed and finalized approval of this document. Trauma Transfer Guideline: All present have reviewed and finalized approval of this document. Nurse Credentialing Requirements: This document has been slightly adapted to move the requirement for PCU RN education to be in the category with the Med-Surg RN category rather than the ICU. All present have reviewed and finalized the approval of this document.
1455-1500 State Trauma System Integration ✓ Indiana State Trauma Care Committee	The next Indiana State Trauma Care Committee and Indiana Trauma Network meetings are schedule August 8th at the ISDH.
1500 Open Forum	

Action Items	**Person Responsible**	**Deadline**
Draft final copy of trauma flowsheet and present to group for approval.	Roxann Kondrat	July 8, 2014
Share 1 success and 1 challenge with the group	Trauma Program Managers	June 8, 2014

Next Meeting: July 8, 2014

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 21

RN CREDENTIALING

"21. **Nurse credentialing requirements:** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 21 are met with a copy of the Community Hospital East RN credentialing requirements covering ICU and ER nurses. The Emergency Department has additional requirements which are delineated in an ER-specific guideline. Also included is a spreadsheet illustrating the training level of each ER RN.

Community Health Network

OPERATIONAL GUIDELINE: EDUCATION REQUIREMENTS FOR THE CARE OF TRAUMA PATIENTS

OBJECTIVE:
To define continuing education requirements and expectations of nursing staff who care for the acute trauma patient.

PROCEDURE:

A. Each associate will be responsible for maintaining their continuing education requirements. Adherence to this guideline is strongly encouraged for CHNw nursing team member that cares for patients on the Trauma Service including supplemental associates (PRN).

   It is the responsibility of each nursing team member to participate in and maintain accurate documentation of their continuing education credits/units. Copies of continuing education credits/units should be given to department leadership and submitted to the appropriate credentialing organization in a timely manner.

B. Indicated verifications are recommended within 18 months from date of hire for new nursing team member or 18 months from the effective date of this guideline, unless otherwise specified. Priority will go to new nursing team members, followed by currently employed nursing team members without trauma experience, and finally, currently employed nurses with trauma experience.

C. See attached table for a complete list of education requirements by individual unit.

Staff	Requirement
Emergency Department ***Nursing staff caring for patients on the trauma service.**	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC) or Advanced Trauma Care Nursing (ATCN) o Encourage certification in the practitioner's area of specialty (i.e.- CEN, CCRN, etc.)
Operating Room	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education

	annually. o Advanced Cardiac Life Support (ACLS) o Encourage certification in the practitioner's area of specialty.
ICU/PACU	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC), Advanced Trauma Care Nursing (ATCN), or Essentials of Critical Care Orientation (ECCO) o Encourage certification in the practitioner's area of specialty.
PCU/Medical-Surgical Units	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Encourage certification in the practitioner's area of specialty.

ENA: Emergency Nursing Orientation On-Line Training
(Assigned to new ED RN hires who have not had ED or ICU training)

Lesson Listings

Foundations of Emergency Nursing Practice
- Introduction
- Legal
- Cultural
- Education

Clinical Foundations of Emergency Nursing
- Assessment and Priority Setting
- Emergency Medical Services/Transport
- Vascular Access
- Wound Management
- Drug Calculations
- Pain Management and Sedation
- End-of-Life Care and Organ/Tissue Donation
- Emergency Operations Preparedness
- Infectious and Communicable Diseases

Special Patient Populations
- Obstetric Emergencies
- Pediatric Emergencies
- Behavioral Health Emergencies
- Violence, Abuse and Forensic Evidence
- Substance Abuse

Major Trauma Emergencies
- Basis of Trauma Management
- Head Trauma
- Spinal Trauma
- Thoracic Trauma
- GI Trauma
- Renal and GU Trauma
- Orthopedic and Neurovascular Trauma
- Burns
- Maxillofacial Trauma
- Pediatric Trauma
- Elder Trauma
- Obstetric Trauma

Medical and Surgical Emergencies
- Respiratory Emergencies
- Cardiovascular Emergencies
- Shock Emergencies
- Neurologic Emergencies
- Gastrointestinal Emergencies
- Renal and GU Emergencies
- Fluids and Electrolytes
- Endocrine Emergencies
- Hematologic Emergencies
- Toxicologic Emergencies
- Gynecologic Emergencies
- Dental, Ear, Nose and Throat Emergencies

COMMUNITY HOSPITALS INDIANAPOLIS
ORIENTATION DOCUMENTATION RECORD

Emergency Department
R.N.

Name: _____ Orientation Start Date:_____ Unit/Dept: _____

Hospital I.D. #:_____ Facility:_____

Most Recent Work Experience and Dates:_____ Education and Dates:_____

The employee is responsible for the timely and accurate completion of the Orientation Documentation Record. Each unit/dept. will have a designated place for the Record during the employee's orientation. The completed documentation record is placed in the employee's permanent personnel file in Human Resources within 6 months of the orientation start date.

A competency-based orientation plan will be developed within the framework of the employee's self-assessment, educational background, work experience, and the role summary.

Competency Statements with Expected Behaviors are the knowledge and skills that an employee must demonstrate for safe and effective health care delivery. Validation will be done in a lab/classroom or clinical/work area, depending on the specific behavior.

Self-Assessment column will be completed within the first week of orientation by employee if he/she has similar work experience. A check mark will be placed in one of the three columns for each competency statement. The non-experienced employee may leave self assessment section blank.

Column 1 - No experience or minimal experience
Column 2 - Need practice/review/instruction of CHI policies and procedures and/or with CHI equipment
Column 3 - Can do (indicates competence based on previous experience)

Instructed column will be initialed and dated when the instruction or self learning activity has been completed. For any competency checked "can do", instruction may be omitted. However, validation of the competency is necessary.

Validated column will be initialed and dated as the competency is demonstrated in the lab/classroom and/or clinical/work area by the person who validates the competency. Validation means the orientee can demonstrate knowledge or perform skills according to CHI standards/policies/procedures without guidance from the person observing. If instruction is required the experience is to be considered instructed rather than validated.

No clinical validation is to occur until valid RN license is obtained. Do not complete the column identified as "validated to clinical/work areas" prior to RN licensure.

The words, "Not Applicable" or "NA" may be written across the columns on an individual's record for any competency deemed required for some but not all members of a work team or department.

Persons who provide instruction and/or validation in addition to writing initials will sign full name one time on the last page of this Orientation Documentation Record.

I understand as a new employee I will not perform skills or give medication, including IV's, until I have been clinically validated by a Community Health Network RN.

I understand as a new employee I will not perform skills or give medication, including IV's, until I have been clinically validated by a Community Health Network RN.

Signature:_____ Date:_____

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
I. Emergency Department Operations **Completes ENA online modules: Intro to ED, Legal, and Patient Education modules as needed**						
A. Identifies patient flow patterns						
B. Cleans rooms between patients per standard						
C. States telephone medical advice procedure						
D. Completes E.D. records in EDS according to policy						
1. Admission Data Base (Triage Record)						
2. Completes Flow sheets, events, assessments						
3. Uses Discharge 1,2,3 instruction sheets						
E. Uses charge stickers and Durable medical goods charge sheets						
F. Explains care of valuables in the E.D.						
G. States AMA/elopement procedure and finds form						
H. Consent for treatment						
I. Accesses E.D. Nursing Protocols and uses with consultation						
J. States procedure for an employee injury						
II. Triage Prioritization and Care Planning						
A. Data Collection appropriate to injury/stated complaint						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
B. Interpret data and designate ESI Triage						
C. Completes ESI Triage learning/ENA Online Priotity Setting as needed						
D. Place patient in area appropriate for triage category and needs						
E. If necessary provides immediate interventions and appropriate transfer of care to health care team colleagues.						
III. Musculoskeletal Emergencies: Completes ENA Orthopedic Trauma module as needed						
A. Assesses injuries and plans care						
B. Intervenes to stabilize injury, decrease disability, minimize bleeding, minimize pain						
C. Evaluates interventions, provides for follow-up, reprioritizes care						
D. Provides Discharge instructions or transfer to inpatient status as appropriate						
E. Applies various straps and splints:						
1. e.g.: ace wrap, clavical strap, shoulder immobilizer, knee immobilizer, Velcro wrist slints, fiberglass splints,air splints						
F. Uses ring cutter properly						
G. Cares for amputated parts						
H. Buddy splints fingers or toes						
I. Finds Compartment Syndrome Test device (Stryker)						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
IV. Surface Trauma: Completes ENA online Wound Managemnt and Burm modules as needed						
A. Assesses and Plans care appropriate to injury						
B. Intervenes to minimize bleeding, disability and pain						
C. Evaluates Interventions and provides for followup						
D. Provides Discharge instructions appropriate to injury or transfers to higher level of care as needed.						
E. Preps wound with sterile technique. Utilizes wound irrigation to clean lacerations.						
F. Sets up for suturing						
G. Obtains wound culture						
1. Aerobic/anerobic						
H. Removes sutures/staples						
I. Applies dressings:						
1. Upper/lower extremity/finger/pressure						
J. Applies steri-strips						
K. Applies LET						
L. Assists with application of Dermabond and applies dressing appropriately						
M. Find Health Dept. Form to report Animal Bites for pt.						
N. Sets up for Incision & Drainage of wounds/ boils						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
O. Utilizes burn care guidelines in planning care of burn pts.						
V. Eye, Ear, Nose, Throat Emergencies: Completes ENA online Ocular, ENT, Maxillofacial modules as needed						
A. Assesses and Plans Care for appropriate condition						
B. Intervenes to minimize bleeding, disability and pain						
C. Evaluates interventions and follows-up, reprioritizes if needed						
D. Provides Discharge instructions or transfers to higher level of care as appropriate.						
E. Assesses visual acuity						
1. Child/ Adult						
F. Performs eye irrigation						
1. Manual/Morgan Lens						
G. Instills eye medications						
H. Applies eyepatch/ eye shield						
I. Finds Tonometer for measuring intraocular pressure						
J. Ear						
1. Irrigates						
2. Instills meds						
K. Nasal packing, assists with						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
1. Anterior/posterior						
L. Cautery, assists with						
1. Silver nitrate sticks						
M. Obtains cultures						
1. Throat/ RSV (nasal)						
N. Indirect laryngoscope						
1. Sets up						
2. Cleans						
VI. GI/GU Emergencies: Completes ENA online GI Trauma, Renal Trauma, GI Emergnecies as needed						
A. Performs abdominal assessment and interventions						
1. Inspects for size, shapes, symmetry, discoloration						
2. Auscultates bowel sounds						
3. Palpates all four quadrants of abdomen						
B. Prioritizes care based on data collection and assessment						
C. Intervenes to minimize pain, bleeding or disability						
D. Evaluates interventions, follows-up, reprioritizes						
E. Provides Discharge instructions or transfers to a higher level of care.						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
F. Inserts nasogastric tube						
G. Administers enema						
H. Inserts urinary catheter						
1. Straight catheter						
a. Male						
b. Female						
2. Indwelling catheter						
a. Male						
b. Female						
I. Removes foley catheter						
J. Assesses urine for amount, color, clarity, sediment, odor						
K. Collects urine specimens including;						
1. CCMS						
2. Sterile						
3. C & S						
L. Performs POC Dipstick Urinalysis						
M. Performs Point of Care Pregnancy Testing						
VII. OB/GYN Emergencies: Completes ENA online Obstetrical Trauma / GYN Emergencies modules as						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
needed.						
A. Assesses and plans care appropriate to needs						
B. Intervenes to minimize pain, bleeding, or disability						
C. Evaluates intervention, follows-up and reprioritizes care						
D. Provides Discharge instructions or transfers to a higher level of care						
E. Sets up for vaginal exam						
F. Collects specimens						
1. DNA probe						
2. Wet mount						
3. Herpes						
G. Preserves products of conception properly						
H. Assists with alleged sexual assault procedure						
1. Calls Sart Team per protocol/ procedure						
2. Triage to Center of Hope as appropriate						
I. Assists with precipitous delivery						
1. Prepares infant warmer						
J. Auscultates for Fetal Heart Tones (FHT)						
VIII. Toxicology: Completes ENA online Substance						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
Abuse/ Toxicology/ Behavioral Health Emergencies as needed						
A. Assesses and Plans care appropriate to needs						
B. Intervenes to minimize toxic effects, pain and disability or prevent death.						
C. Evaluates intervention, follows-up and reprioritizes						
D. Provides transfer to higher level of care or discharge instructions as appropriate.						
E. Obtains blood specimen for alcohol level						
1. Routine						
2. Police request						
F. Accesses the poison control system						
1. Poison control center						
G. Administers activated charcoal						
IX. Infectious Diseases: Completes ENA online Hematologic Emergencies as needed						
A. Assesses and Plans Care appropriate to needs						
B. Intervenes to prevent the transmission of disease and minimize disability						
C. Evaluates interventions, follows-up, reprioritizes						
D. Provides Discharge instructions or transfer to higher level of care*						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
E. Demonstrates infection control measures in the clinical setting by demonstrating handwashing and by:						
1. Utilizes body substance isolation when caring for all patients.						
2. Initiates transmission based isolation techniques						
3. Accesses resources for needlestick protocol						
F. Demonstrates methods for contact isolation						
G. Administers First Dose Antibiotics as stat order						
X. General Medical Emergencies: Completes ENA online modules: Fluid/Eletrolytes,Endocrine, Vascular Access, Drug Calculations						
A. Assesses and Plans Care appropriate to needs						
B. Intervenes to minimize pain or disability						
C. Evaluates interventions, follows-up, reprioritizes care						
D. Provides transfer to higher level of care or discharge instructions						
E. Performs phlebotomy						
1. Routine						
2. Blood cultures						
3. Draws blood from IV site						
F. Uses blood glucose monitor and ISTAT properly						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
G. Accesses Pyxis Medstation						
H. Administers blood and blood products Completes on line Blood Transfusion learning						
1. Obtains consent						
2. Properly documents						
3. Uses blood infusion devices properly (warmer, rapid infuser, alaris pump)						
4. States sign/symptoms of transfusion reaction and appropriate interventions.						
I. Performs the following intravenous processes:						
1. Venipuncture						
a. Insyte/ Autoguard						
b. Twin Cath						
2. Prepares IV fluids for gravity infusion						
3. Prepares IVF with additives						
4. Properly times an IV bag						
5. Converts IV to PRN adapter						
6. Performs IV system check per policy						
7. Dresses IV site OP Site 3000						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
8. IV volumetric pump						
a. Programs						
b. Troubleshoots						
J. Administers intravenous medication properly						
1. IVP						
2. IVPB						
3. Monitors patients during conscious sedation: airway management, pulse oximetry, cardiac monitor, vital signs, recovery and discharge instructions.						
K. Central venous catheter						
1. Assists with insertion						
2. Applies sterile dressing/ Op site 3000						
3. Flushes properly						
4. Draws blood specimens						
L. Administers medications by the following routes:						
1. P.O.						
2. IM/ Z-track						
3. SQ						
4. Rectal						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
M. Prepares a patient for surgery						
1. Completes pre-op checklist						
2. Obtains consent						
N. Utilizes noninvasive BP monitors appropriately						
O. Obtains orthostatic vital signs						
XI. Neurological Emergencies: Completes ENA online Head, Spine, Neurolgic Emergencies as needed						
A. Assesses and plans care appropriate to needs						
B. Intervenes to minimize pain, disability or prevent death						
C. Evaluates interventions, follows-up, and reprioritizes care						
D. Provides transfer to higher level of care or discharge instructions						
E. Obtains and documents Glasgow Coma Score (GCS) all Trauma patients						
F. Assesses and documents neurological status						
G. Initiates seizure precautions						
H. Initiates code stroke protocol						
I. Assesses patient using the NIH Stroke Scale						
J. Assists with lumbar puncture						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
XII. Special Patient Population: Pediatrics, Completes ENA online Pediatric/Abuse modules as needed						
A. Assesses and plans age appropriate care						
B. Intervenes to minimize pain, bleeding, disability or prevent death*						
C. Evaluates interventions, follows-up and reprioritizes care						
D. Provides discharge instructions or transfers to higher level of care as appropriate.						
E. Performs the following IV processes on infants/children						
1. Venipuncture						
a. Insyte/Autoguard						
2. Set up of IV fluids (incl. Buretrol when appropriate)						
F. Performs phlebotomy						
1. Routine						
2. Blood cultures						
G. Restrains pediatric patient – papoose and sheet mummy						
H. Assists with lumbar puncture						
I. Files DPW 310 child abuse form when appropriate						
J. Checks pediatric code cart						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
K. Demonstrates Broselow tape/system						
L. Provides fever care						
1. Meds						
2. Sponge bath						
M. Administers medications by the following routes:						
1. Oral						
2. IM						
3. Sub q						
4. Rectal						
N. Intraosseous insertion assists with procedure and secures I/O device.						
XIII. Special Patient Population: Geriatrics Completes ENA online Elder Trauma/Cultural Dimensions as needed						
A. Assesses and Plans Age appropriate care						
B. Intervenes to minimize pain, bleeding or disability or provide for comfortable, dignified death						
C. Evaluates interventions, follows-up, reprioritizes care						
D. Transfers to a higher level of care, or provides discharge instructions						
E. States procedure to report elderly abuse						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
F. Accesses resources for emergency placement in E.C.F.						
G. Utilizes protective restraints only after other measures fail						
H. Initiates protective restraints per policy						
XIV. Psychiatric Emergencies: Completes Bevioral Care ENA module as needed						
A. Assesses and plans care appropriate to needs. Uses Crisis Intervention triage techniques.*						
B. Intervenes for a safe environment in behavioral crises						
C. Evaluates interventions, follows-up and reprioritizes care						
D. Provides discharge instructions or transfer to higher level of care						
E. Uses restraints according to behavioral restraint policy						
F. Initiates suicide precautions, i.e., protective environment						
G. States procedure for patients under immediate detention						
H. States procedure for admission or transfer to Mental Health Center						
XV. Environmental Emergencies Completes ENA Shock Emergnecies module as needed						
A. Assesses and Plans care for selected environmental emergencies						
B. Triages Hazmat patients, minimizing exposure of staff or other patients or visitors.*						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
C. Intervenes to minimize disability and safe care for patient and staff						
D. Evaluates interventions, follows-up, reprioritizes care						
E. Provides discharge instructions, or transfer to higher level of care.						
F. Performs or states proper decontamination of Hazmat patients						
G. Uses hypo/hyperthermia blankets properly						
XVI. Oncological Emergencies: Completes Pain management /Sedation ENA online module as needed						
A. Assesses and Plans Care appropriate to patient needs						
B. Intervenes to minimize pain or disability, or provides for comfortable death.						
C. Evaluates interventions, follows-up and reprioritizes care						
D. Provides transfer to higher level of care or discharge instructions*						
E. Accesses silastic catheter						
1. Obtains lab specimen						
2. Provides fluid therapy						
F. Accesses a Port-A-Cath properly						
1. Obtains lab specimen						
2. Provides fluid therapy						

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
G. Accesses PICC line properly						
XVII. Respiratory Medical Emergencies: Completes ENA online Resp. Emergencies as needed						
A. Assesses respiratory status and plans care						
1. Inspects chest for depth, rhythm, rate, symmetry						
2. Auscultates lungs for equal breath sounds						
3. Identifies adventitious breath sounds						
a. Crackles						
b. Wheezes						
c. Rhonchi						
4. Utilizes Pulse Oximetry in assessment						
5. Utilizes Capnography on monitor for selected patients						
B. Patient care teaching with asthma						
C. Intervenes /maintains supplemental oxygen via:						
1. Nasal cannula						
2. Non-rebreather mask						
3. Bag-valve mask						
D. Inserts and/or maintains artificial airways properly						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
1. Oropharyngeal						
2. Nasopharyngeal						
E. Obtains peak flow measurement						
F. Utilizes and troubleshoots pulse oximeter						
G. Assists with:						
1. Intubation						
2. Cricothyrotomy						
H. Suctions						
1. Orally						
2. Nasally						
3. ETT						
I. Draws Arterial blood gases (ABG's)—performs Allen's test before radial puncture						
J. Interprets ABG results and intervenes						
K. Evaluates plan of care and reprioritizes care						
L. Provides transfer to higher level of care or discharge teaching and instructions as appropriate						
M. Recognizes key ventilator settings and alarms						
1. Responds to alarms						
2. Manually ventilates patient until alarms						

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
resolves						
XVIII. Cardiovascular Emergencies: Completes ENA online CV/Shock/ as needed						
A. Assesses cardiovascular status and plans care						
1. Assesses skin color, temp, turgor, edema, diaphoresis, pain						
2. Assesses capillary refill, skin color and temp						
3. Auscultates heart sounds (S1, S2)						
4. Palpates peripheral pulses for rhythm, amplitude, and bilateral equality						
B. Initiates cardiac monitoring:						
1. Applies leads for Lead II monitoring						
2. Assigns patient name and number to monitors						
C. Performs defibrillation						
D. Performs synchronized cardioversion						
E. Performs 12 lead EKG						
F. Accurately interprets dysrhythmias and appropriate interventions.						
G. Sets up and maintains external pacemaker properly						
H. Acquires ACLS training (within one year of hire to the Emergency Department)						
I. Hemodynamic monitoring						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
1. Arterial line						
a. Sets up and Zero's line						
b. Assists with insertion						
J. Evaluates Interventions, follows-up, reprioritizes care						
K. Transfers to higher level of care or provides discharge instructions.*						
L. Cares for patient with chest pain – assesses and documents:						
1. Assures EKG within 5 min of arrival						
2. Assures transfer to Cath lab is timely within 30 min.						
3. Unfractionated Heparin bolus and infusion						
4. Platelet inhibitors (Aspirin, Plavix and GBIIB/IIIA inhibitors)						
5. Low molecular weight Heparin subcutaneous						
6. Nitroglycerin, sublingual or infusions						
XIX. Multiple Trauma: Completes ENA Trauma Management module as needed						
A. Performs a primary assessment and intervenes						
B. Performs a secondary assessment and prioritizes care						
C. Intervenes to minimize bleeding, pain or disability						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
D. Evaluates interventions, follows-up, reprioritizes care						
E. Transfers to higher level of care or provides discharge instructions.						
F. Uses/maintains spinal immobilization devices:						
1. Cervical collar						
2. Backboard						
G. Sets up for:						
1. Chest tube insertion						
2. Needle thoracostomy						
XX. Organ Procurement: Completes ENA Organ procurement module as needed						
A. Calls IOPO on death of pt. to determine eligibility for tissue donation						
B. Death procedure						
1. Notifies coroner						
2. Completes RHC records						
3. Post mortem care						
XXI. Emergency Preparedness: Completes ENA online EOP as needed						
A. Describes disaster procedures						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
XXII. Emergency Medial Services System: Completes ENA EMS module as needed						
A. Completes transfer records in compliance with EMTALA						
B. Participates in EMS radio communication-IN Hospital Emergency Radio Network (IHERN)						
C. Stores EMS equipment appropriately						
XXIII. Clerical Skills						
A. Completes EDS training						
1. Performs order entry						
2. Order cancellation						
3. Prints specimen requisitions						
4. Accesses result inquiry						
B. Uses intercom system properly						
XXIV. Professional Practice/Leadership						
A. Identifies personal strengths and areas for growth						
1. Sets goals during orientation						
2. Sets goals at exit conference for next 6 months						
B. Utilizes resources within the department for self learning						
C. Communicates learning needs to preceptors, resource instructor, and/or team leader						

RN – Emergency Department

Competency Statement with Expected Behavior	Self Assessment: No Experience	Need Practice/ Review/ Instruction	Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
D. Completes Basic Physical Examination Data Collection CAP						
XXV. Performs and/or supports the primary nurse role as defined by unit standards						
A. Identifies responsibilities of primary nurse and other E.D. personnel						
B. Performs the role and responsibilities of primary nurse towards end of orientation period with use of available resource personnel and guidance.						
C. Delegates care appropriately to non licensed personnel and follows up on interventions requested.						

I acknowledge that:

1. I am responsible for utilizing Community Hospital policies, procedures, and standards.
2. I am accountable for my ongoing professional development and utilizing resources as needed.
3. I am responsible for seeking and utilizing assistance for patient care in which I am not competent and/or experienced.

_____

Date and Employee Signature

Instructors and Validators: (Signatures)	(Initials)	Instructors and Validators: (Signatures)	(Initials)

RN – Emergency Department

Orientation Documentation Record reviewed by: _____

Date and Leadership Signature

Send Orientation Documentation Record to Human Resources to be placed in employee's file within two weeks of orientation completion date and not to exceed six months from orientation start date.

All experiences may not be available for validation of competency during the initial orientation period. List any competencies that have not been validated on a Competency Development Action Plan (Goal) form. Validate these competencies prior to the annual performance appraisal.

Continuation of Orientation Documentation

Utilize this form for documentation of competencies not obtained during initial orientation.

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			

_____

Date & Employee Signature

Reviewed By:_____

Date & Clinical Leadership

Send to Human Resources to be filed in employee's permanent record.

Emergency Service Line
Quality Safety Management/Scope of Service Plan (CHE)

Hours of operation 24/7 with continual RN/MD staffing

Goal: To deliver quality medical care in a safe and timely manner, to all those seeking emergency medical treatment.

Scope: The emergency department will provide acute care services to all patients presenting for treatment within our capabilities. Patients requiring services outside our capabilities will receive diagnostic and stabilizing treatment followed by transfer to appropriate facilities

Types of service:

- Medical Surgical
- Neurological
- Cardiac
- Minor/Moderate trauma
- Access to all specialties providing on-call coverage
- Inpatient services on-campus with the following exceptions
    - East: no on-campus pediatric inpatient services – transfer to North campus
    - All behavioral care inpatient services located on the North campus
    - No pediatric intensive care services outside the NICU located on North campus
- Orthopedic

Population: Patients of all ages served

Assessment/Treatment: Patients progress through a process of RN triage assessment and MD medical screening exam. Necessary diagnostic and stabilizing treatment is provided based on the needs of the patient's condition. Disposition is determined by the physician, with consults conducted with primary care physicians and specialists as indicated.

Staffing effectiveness: MD and RN/support services coverage is determined within each emergency department in the service line to meet the volume and acuity needs specific to each site. The following indicators can be monitored to determine the effectiveness of each site's staffing plan:

- AMA/Elopement rates
- Length of stay
- Patient satisfaction/feedback
- Safety indicators

Community Hospital East
Emergency Department Patient Care Standards

STANDARD 1

EMERGENCY NURSES SHALL TRIAGE EVERY PATIENT ENTERING THE EMERGENCY CARE SYSTEM AND DETERMINE PRIORITIES OF CARE BASED ON PHYSICAL AND PSYCHOSOCIAL NEEDS, AS WELL AS FACTORS INFLUENCING PATIENT FLOW THROUGH THE SYSTEM.

GUIDELINES

1. Upon presentation to the Emergency Department all patients will be assessed by a Registered Nurse.

2. All patients will be triaged according to the severity of the problem.

3. RN Intervention will include the use of the ESI Tool to determine acuity and resources needed:

   ESI Algorithm – It yields rapid, reproducible, and clinically relevant stratification of patient into five groups, from Level I (most urgent) to Level 5 (least urgent). The ESI provides a method of categorizing ED patients by both acuity and resource needs.

   Decision A – Immediate life saving intervention required. Does the patient require an immediate airway, medication, or other hemodynamic intervention?
   Decision B – Once it is determined, they do not meet ESI Level 1 the nurse needs to decide whether this patient should wait to be seen. Is this a high-risk situation? or confused/lethargic/ disoriented? or severe pain/distress?
   Decision C – If no, to the two above decisions then the nurse should ask, "How many different resources do you think this patient is going to consume in order for the physician to reach a disposition decision? None? One? Or Many?
   Decision D- Before assigning to a level 3 ESI the vital signs must be reviewed and determined if they are outside the normal parameters for age. This may cause the ESI to be bumped back up to a ESI 2.
   ESI Levels – Level I – life threatening; Level 2 high risk situation; Level 3 two or more resources; Level 4 one resource; Level 5 no resources.

4. All patients will give consent for treatment whether it is implied or written.

5. A medical screening exam will be provided to all patients, who present to the Emergency Department, to ascertain if the patient has an emergency medical condition

6. All patients will have identification armbands.

7. All females between ages of 10 and 50 will have their pregnancy status documented before treatment is rendered.

8. All patients who present for treatment, regardless of their ability to identify themselves will be treated:

a) All medically stable patients must be verbally identified by themselves or attending family/ caregivers, or identified by identification band, before treatment will be rendered in the Emergency department.

b) Unstable patients will be treated immediately without regard to identification. Attempts will be made as soon as possible to obtain identification of the patient as soon as they are stabilized.

c) All confused or demented patients will be identified upon arrival, either verbally by a family member/caregiver, or by identification band/tag.

d) If the patient cannot identify themselves and there is no identification band or caregiver accompanying patient, then:

i. Patients from extended care facilities: Facility will be notified to send a caregiver to the Emergency Department who can positively identify the patient, or a family member could come to identify the patient. .

ii. If after reasonable attempts, the staff is unable to obtain identification, the staff will notify the facility and the patient will be returned to the point of origin after a medical screening exam has been done.

STANDARD 2

EMERGENCY NURSES SHALL INITIATE ACCURATE AND ONGOING ASSESSMENTS OF PHYSICAL AND PSYCHOSOCIAL PROBLEMS OF PATIENTS WITHIN THE EMERGENCY CARE SYSTEM.

GUIDELINES

1. The patient's specific problem will be identified and documented utilizing objective and subjective data.

STANDARD 3

THE EMERGENCY NURSE ANALYZES ASSESSMENT DATA TO FORMULATE NURSING DIAGNOSES AND IDENTIFIES COLLABORATIVE PROBLEMS FOR EACH PATIENT.

1. Care for adult patients will be developed and prioritized using TNCC and ACLS guidelines.

2. Care for pediatric patients will be developed and prioritized using PALS guidelines.

STANDARD 4 PROFESSIONAL EDUCATION

THE EMERGENCY NURSE RECOGNIZES SELF - LEARNING NEEDS AND IS ACCOUNTABLE FOR MAXIMIZING PROFESSIONAL DEVELOPMENT AND OPTIMAL EMERGENCY NURSING PRACTICE.

GUIDELINES

1. The nurse participates in ongoing educational activities related to clinical knowledge and professional issues.

2. The nurse seeks experiences to maintain clinical skills.

3. The nurse seeks knowledge and skills appropriate to the practice setting.

4. Core Competencies are validated annually.

5. Yearly mandatory in-services are completed.
6. BLS required
7. ACLS Required within 12 months of hire and recertified every 2 years
8. PALS Required within 12 months of hire and recertified every 2 years
9. TNCC Required for all RN's within 18 months of hire and recertified every 4 years (Effective March 31st 2014 and based on class availability)

*Standards are effective for all new hires after March 31st 2014, current employee's must comply with PALS and TNCC by 2016

10.

STANDARD 5

EMERGENCY NURSES SHALL IMPLEMENT A PLAN OF CARE BASED ON ASSESSMENT DATA, NURSING DIAGNOSIS, AND MEDICAL DIAGNOSIS.

GUIDELINES

1. Nursing interventions will be implemented according to nursing assessment and established practice.

2. Emergency Department protocols will be instituted by the RN dependent upon patient presentation and assessment.

3. All patients who have medications or treatments ordered will have the orders written on the Emergency Department record or the Physician Order sheet. No verbal orders will be acted upon until they are documented, except in emergency situations.

4. Nursing protocols will be initiated when indicated.

5. Care will be developed and prioritized using TNCC, ACLS, , and PALS guidelines.

STANDARD 6

EMERGENCY NURSES SHALL EVALUATE AND MODIFY THE PLAN OF CARE BASED ON OBSERVATION RESPONSES OF PATIENTS AND ATTAINMENT OF PATIENTS OUTCOMES AND PATIENT GOALS.

GUIDELINES

1. All patients who receive medication to promote the relief of symptoms will have their responses documents on the Emergency Department Record.

2. Non - monitored patients' vital signs will be repeated based on their condition and/or treatment.

3. Monitored patients will have vital signs repeated with the frequency necessitated based on their ongoing assessment and according to policy.

4. Neurovascular assessments will be completed at the time of triage, prior to splinting or casting, following splinting or casting, or at discharge.

5. The physician will be apprised of significant findings and patient conditions.

6. Patients, who experience extended stays in the Emergency Department, will be reassessed by an RN every 12 hours or more frequently as patient condition warrants to determine appropriate bed placement.

   a) The RN reassesses for the following criteria:

      i) EKG pattern is unchanged (2)
      ii) Cardiac enzymes are within normal limits (2 sets). If patient has positive cardiac markers or Troponin , consult with physician.
      iii) Pain is controlled without IV medication administration or no more than one Sublingual Nitroglycerin.
      iv) The patient is not on IV medications of Nitroglycerin, pressors or antiarrythmics.

   b) The RN will contact the admitting physician between the hours of 0700-2200 for re-evaluation of patient placement if the patient meets the above criteria.

   c) Admissions will be notified of any orders modifying the patient's bed status.

STANDARD 7

EMERGENCY NURSES SHALL PROVIDE CARE BASED ON PHILOSOPHICAL AND ETHICAL CONCEPTS, SUCH AS REVERENCE FOR LIFE AND A RESPECT FOR THE INHERENT DIGNITY, WORTH, AUTONOMY, AND INDIVIDUALITY OF EACH HUMAN BEING AND ON A RESOLUTION TO ACT DYNAMICALLY IN RELATION TO PEOPLE'S BELIEFS.

GUIDELINES

1. All competent patients have the right to refuse treatment or medications.

2. Patient confidentiality and privacy will be maintained, living wills and DNR orders will be honored, and patients will be treated in a non-judgmental manner.

STANDARD 8

EMERGENCY NURSES SHALL ASSURE OPEN AND TIMELY COMMUNICATION WITH EMERGENCY PATIENTS, THEIR SIGNIFICANT OTHERS, AND TEAM MEMBERS.

GUIDELINES

Patients will be rounded on at least hourly, emphasizing pain assessment, plan of care and duration(estimated length of stay). The Healthcare professional will document hourly rounding on in room logs and in the EMR when necessary. In room whiteboards will be updated as needed to include but not limited to the following essential items; Name of healthcare providers, date, necessary treatment or tests and other pertinent information deemed essential by the healthcare professional to the care of the patient. If the patient has questions about a test or treatment, the test/treatment will be delayed until an RN or physician can answer the questions. (*Exceptions: In life threatening situations, i.e. in the shock/trauma room, when urgency is of paramount importance, this may not always be possible.)*

1. Patients' significant others will be kept informed of the patients' treatment per HIPAA guidelines. Patients and their significant others will be kept aware and involved in the patients' plan of care and any delays.

2. Patients have the right to refuse any care ordered. If the patient refuses care the reasons why the care was ordered and the health risks associated with refusal of care are discussed with the patient. Refusal of care is documented in the medical record.

3. All patients seen in the Emergency Department will have an Outpatient Treatment record generated.

4. All patients who have medication given or treatments initiated will have them clearly documented on the electronic bedside documentation record.

5. Pertinent patient data, nursing interventions, and patient responses will be documented in the electronic bedside documentation record.
6. All patients/significant others receive written discharge instructions and appropriate patient teaching.

7. All patients are reassessed by an RN at discharge.

    a) The nurse verifies that all discharge orders complete and the patient/significant other understand the instructions and that all temporary invasive lines are removed.

b) The nurse will assess the mode of transportation available for the patient at discharge is appropriate.

c) Patients who are to do no weight bearing, or have received a narcotic or sedating medication will be discharged via wheelchair.

Patients receiving a narcotic or other sedating medication can be discharged utilizing the following guidelines after physician evaluation and discharge order..
a. Blood Pressure plus or minus mm Hg prior to administration.
b. ability to ambulate as on arrival or better.
c. Absence of vomiting
d. Absence of repiratory distress
e. Alert and oriented to surrounding and events
f. The final disposition decision is always determined by the physician

8. Telephone medical advice is not provided by Emergency Department personnel regarding care or treatment of any illness or injury

a) If medical care is needed for possible poison ingestion, the caller will be referred to Poison Control at 923-2323.
b) For EMERGENT situations, callers are instructed to go to the nearest Emergency Department or call 911.
c) For NON-EMERGENT situations, callers are encouraged to seek medical attention if they have a health concern.

Service Line Customers:

- Patients within our service area
- Network employees
- Network physicians
- Ancillary services

Quality/Safety Initiatives:

- Galaxy Fall Project: Morse fall scale completion
- 2-patient identifier: Use of arm bands to identify name/date of birth as identifiers for procedures and medications
- Ongoing education and process work to meet pneumonia 6hr door-drug goals
- Ongoing work with cardiac services to meet quality goals for AMI
- Staffing and process plans to decrease AMA/Elopement rates while improving overall throughput times

References:

Policy-CORP#CLN-2005

Policy-NPP#..ED-M003

Emergency Nurses Association. (2007). TNCC: *Trauma nursing core course* (6th ed.). Des Plaines, IL: Author.

NAME	ACLS EXPIRES	PALS EXPIRES	TNCC EXPIRES	ENPC EXPIRES
Aaron, Andrea, RN	3/2016	5/2015	12/2014	12/2014
Allen, Jon, RN	10/2014	10/2014	5/2017	8/2017
Arnold, Alison, RN	2/2015	8/2015	11/2014	10/2014
Arnold, Susan, RN	11/2015	5/2015	expired	x
Baldridge, Elizabeth, RN	3/2015	3/2015	scheduled 11/2014	x
Bell, Deborah, RN	11/2015	11/2015	expired	x
Biddinger, Heather, RN	2/2015	3/2015	expired	x
Bilyeu, Chuck, RN	11/2015	5/2015	expired	x
Bishop, Steven, RN	8/2015	9/2016	6/2017	x
Bonnell, Emily, RN	10/2014	10/2014	5/2017	6/2017
Bowens, Nakia, RN	1/2015	11/2015	3/2018	x
Buchwald, Carly, RN	4/2015	5/2016	1/2018	x
Cartwright, Danae, RN	12/2014	1/2015	5/2017	4/2017
Croddy, Kristi, RN	9/2014	8/2015	6/6/2018	x
Culp, Melanie, RN	5/2016	8/2014	7/2016	10/2016
Cummings, Patty. RN	2/2015	3/2015	expired	x
Durham, Jennifer, RN	9/2014	9/2014	11/2017	12/2017
Evancho, Carrie, RN	3/2015	11/2015	11/2014	121/2014
Gardner, Chad. RN	9/2014	5/2015	6/26/2018	x
Garvin, Angela, RN	8/2015	6/2014	expired	x
Gelopulos, April, RN	5/2016	3/2015	expired	x
Gill, Jeremy, RN	10/2015	8/2014	new hire	x
Gramse, Jane, RN	9/2014	3/2015	6/26/2018	x
Griffin, Bridgette, RN	12/2015	11/2015	6/6/2018	x
Hannigan, Jennifer, RN	3/2015	5/2015	expired	x
Hatch, Mandy, RN	7/2014	9/2014	9/2015	10/2015
Hensley, DeAnn, RN	11/2015	8/2015	expired	x
Horsman, JoAnna, RN	4/2015	5/2015	6/26/2018	x
Irvin, Patricia, RN	11/2015	11/2015	expired	x
Kean, Megan, RN	2/2015	11/2015	3/2015	10/2015
Kindle, Katina, RN	2/2015	3/2015	expired	x
Kocsis, Nick, RN	10/2015	scheduled 7/2014	11/2016	12/2016
Koleszar, Beth, RN	3/2015	3/2015	expired	x
Lockhart, Stacie, RN	11/2015	10/2014	5/2017	6/2017
Lord, Jared, RN	5/2016	1/2015	5/2017	8/2017
Lord, Melanie, RN	6/2015	7/2015	1/2018	x
Manning, Lesa, RN	3/2016	9/2015	2/2018	12/2017
Marquess, Mona, RN	5/2016	11/2015	expired	x
May, Kasey, RN	10/2015	10/2014	5/2017	6/2017
McAree, Helen, RN	3/2016	3/2015	expired	x
McFarland, Linda, RN	2/2016	4/2015	expired	x
McGivern, Kathryn, RN	5/2016	1/2015	7/2017	x
Munden, Angela, RN	12/2015	11/2015	6/6/2018	x
O'Riley, Molly, RN	7/2014	7/2014	5/2015	x

NAME	ACLS EXPIRES	PALS EXPIRES	TNCC EXPIRES	ENPC EXPIRES
Pabst, Cassie, RN	2/2015	11/2015	1/2016	4/2016
Parker, Amanda RN	9/2014	12/2015	expired	x
Pedrazza, Debbie, RN	1/2015	3/2015	1/2015	2/2015
Rapp, Kristin, RN	3/2016	10/2014	expired	x
Reed, Matt, RN	5/2016	11/2015	11/2017	10/2017
Reighley, Jerry, RN	9/2014	9/2014	1/2018	x
Richard, Kim, RN	3/2015	8/2015	expired	x
Schinbeckler Kendra, RN	2/2015	3/2015	expired	x
Sering, Juliema, RN	4/2015	3/2015	4/2015	12/2017
Sherwood, Emily, RN	10/2015	10/2015	5/2017	8/2017
Smith, Charity, RN	3/2016	8/2014	3/2017	3/2017
Smith, Larissa, RN	5/2016	3/2015	9/2017	x
Smith, Tracy, RN	4/2015	10/2014	11/2016	4/2016
Theobald, Sheila, RN	3/2016	6/2016	expired	x
Toth, Janet, RN	3/2015	6/2014	11/2017	8/2017
Travillian, Holly, RN	9/2014	12/2014	5/2018	x
Vagus, Shelly, RN	4/2015	3/2015	expired	x
Vaughn, Yolanda, RN	9/2014	8/2015	expired	x
Wadleigh, Judy, RN	11/2015	11/2015	6/26/2018	x
Wall, Megan, RN	5/2015	11/2015	scheduled 7/2014	x
Wegley, Arthur, RN	4/2015	3/2015	new hire	x
White, Diana, RN	11/2015	11/2015	6/6/2018	x
Wilkinson, Janet, RN	3/2016	6/2014	expired	x
Williamson, Abigail, RN	5/2016	10/2014	5/2016	8/2017
Zeller, Michelle, RN	9/2015	9/2014	11/2016	8/2017
Ziperman, Karen, RN	2/2015	9/2014	9/2017	10/2017
Amos, Heather, EMT-P	4/2015	3/2015	x	x
Bowersox, William, EMT-P	1/2016	6/2016	x	x
Burden, Scott, EMT-P	11/2015	10/2015	x	x
Cuma, Leslie, EMT-P	6/2015	5/2015	x	x
Garard, Clayton, EMT-P	9/2015	3/2015	x	x
Gates, Jacquelyn, EMT-P	4/2015	5/2015	x	x
Hall, Keith, EMT-P	4/2015	scheduled	x	x
McQuiston, Bryan, EMT-P	5/2015	6/2014	x	x
Purkey, Kylie, EMT-P	12/2015	3/2015	x	x
Schutt, Charles, EMT-P	9/2014	6/2014	x	x
Wallace, Allan, EMT-P	1/2015	11/2016	x	x
Williamson, Joy, EMT-P	8/2015	11/2015	x	x

COMMUNITY HOSPITALS OF INDIANA, INC.

COMMUNITY HOSPITALS NORTH, SOUTH AND EAST
AND
COMMUNITY BUSINESS INNOVATIONS
HUMAN RESOURCE POLICY AND PROCEDURE

POLICY TITLE: NEW EMPLOYEE HOSPITAL AND DEPARTMENTAL ORIENTATION PROGRAMS
POLICY NUMBER: 2A

Date Issued: 1/1/99
New: No Update: Yes
Date Originally Issued: 7/29/76
Date Last Reviewed: 4/1/09

STATEMENT OF PURPOSE:
To define the responsibilities and processes associated with Community and Departmental Orientation Programs for new employees.

POLICY:
NEW EMPLOYEE ORIENTATION PROGRAM:

A. All new employees including contract employees must complete a Hospital Orientation Program as scheduled by Human Resources.

B. Employees who have been separated for one (1) year or more, and who return to employment at Community, will be scheduled to attend. As evidence of their attendance, a copy of the Hospital Agenda, which is to be signed and dated by the employee, will be placed in the employee's personnel file – tracked and/or recorded through the electronic educational system.

C. Any reschedules into the assigned Hospital Orientation Program is managed by the new employee and their Leader and must be completed within **ninety (90) days** from the hire date or the new employee is removed from the schedule.

DEPARTMENTAL ORIENTATION PROGRAM

A. The Leader will forward the Department Orientation Checklist (see online forms) to Human Resources within ninety (90) days of the date of hire or date of transfer. Contracted employees checklist will be retained in departmental file.

B. Sr. leadership will be notified if any employee is found out of compliance with any of the above mentioned time frames.

RELATED FORMS:
Employee Orientation Schedule
Department Orientation Checklist

APPROVED BY: _____
PRESIDENT

COMMUNITY HOSPITALS INDIANAPOLIS
ORIENTATION DOCUMENTATION RECORD

Critical/Intensive Care
RN

Name:_____ Orientation Start Date:_____ Unit/Dept:_____

Hospital I.D. #:_____ Facility:_____

Most Recent Work Experience and Dates:_____ Education and Dates:_____

The employee is responsible for the timely and accurate completion of the Orientation Documentation Record. Each unit/dept. will have a designated place for the Record during the employee's orientation. The completed documentation record is placed in the employee's permanent personnel file in Human Resources within 6 months of the orientation start date.

A competency-based orientation plan will be developed within the framework of the employee's self-assessment, educational background, work experience, and the role summary.

Competency Statements with Expected Behaviors are the knowledge and skills that an employee must demonstrate for safe and effective health care delivery. Validation will be done in a lab/classroom or clinical/work area, depending on the specific behavior.

Self-Assessment column will be completed within the first week of orientation by employee if he/she has similar work experience. A check mark will be placed in one of the three columns for each competency statement. The non-experienced employee may leave self assessment section blank. Any skills or tasks assessed as "no experience" or "need practice/review instruction" will require direct observation when performing.

Column 1 - No experience or minimal experience
Column 2 - Need practice/review/instruction of CHI policies and procedures and/or with CHI equipment
Column 3 - Can do (indicates competence based on previous experience)

Instructed column will be initialed and dated when the instruction or self learning activity has been completed. For any competency checked "can do", instruction may be omitted. However, validation of the competency is necessary.

Validated column will be initialed and dated as the competency is demonstrated in the lab/classroom and/or clinical/work area by the person who validates the competency. Validation means the orientee can demonstrate knowledge or perform skills according to CHI standards/policies/procedures without guidance from the person observing. If instruction is required the experience is to be considered instructed rather than validated.

No clinical validation is to occur until valid RN license is obtained. Do not complete the column identified as "validated to clinical/work areas" prior to RN licensure.

The words, "Not Applicable" or "NA" may be written across the columns on an individual's record for any competency deemed required for some but not all members of a work team or department.

Persons who provide instruction and/or validation in addition to writing initials will sign full name one time on the last page of this Orientation Documentation Record.

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
E. Utilizes CIS Technologies						
1. Assessment Form						
III. Assesses patient data to identify health care needs.						
A. Collects assessment data using Nursing Admission Data Base.						
B. Performs ongoing assessment according to CHI policy and procedure and level of care guidelines.						
1. Head-to-toe						
2. Systems Review						
3. Focused Reassessment						
4. Completes Basic Physical Assessment CAP						
C. Correlates lab values with clinical assessment and initiates appropriate interventions.						
1. Potassium						
2. Troponin/CPK						
3. PTT/INR/ACT						
4. ABGs						
5. Drug levels						
6. Other labs relevant to patient's primary/admitting diagnosis, concurrent medical conditions or past medical history.						
D. Assigns level of care appropriate for patient needs.				CLN-2081		
IV. Plans nursing care from identified nursing diagnoses/collaborative problems on focused needs.						
A. Follows plan of care as outlined on Patient Care Pathway.						

RN Critical/Intensive Care

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
b. Consistently utilizes two patient identifiers.						
c. Controlled substances, administration, waste & discrepancies						
d. Epidural/Intrathecal						
e. Eye Drops						
f. IM						
f. Insulin Administration:						
(1) Single dose						
(2) Mixed dose						
(3) Sliding scale						
(4) Continuous infusion						
(5) Insulin Pumps						
g. Intermittent IV Infusion (IVPB)						
h. IV Push						
i. Metered dose inhaler						
j. NG/G-tube/J-tube/OG						
k. Oral						
l. PCA						
m. SQ/Intrafat						
n. Sublingual						
o. Suppository						
p. Topical/patches						
q. Z-tract						
3. Intravenous Procedures:						

RN Critical/Intensive Care

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
(3) Changes tubing						
(4) Dressing change – multilumen cath						
(5) Discontinues multilumen cath						
(6) Discontinues PICC						
(7) Flushes capped ports using positive pressure and appropriate heparin flush						
(8) Draws blood from CVC's/PICC's						
(9) Draws blood from PICC						
k. Peripheral Blood Draws:						
(1) Routine						
(2) Blood culture						
(3) T & C						
4. GI Procedures:						
a. Naso/Orogastric/Enteral Tubes						
(1) Insertion						
(2) Feedings:						
(a) Intermittent						
(b) Continuous						
(3) Irrigation/maintenance						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(2) Temporary dialysis catheter						
(3) CAPD						
(4) Hemodialysis						
(5) Continuous renal replacement therapy						
6. Respiratory Procedures:						
a. Suctions tracheostomy (cath & glove)						
b. Performs trach care						
(1) disposable						
(2) nondisposable						
c. Changes trach ties						
d. Administers oxygen via appropriate device						
(1) Nasal cannula						
(2) Mask						
a. venturi						
b. non-rebreather						
c. simple						
(3) Trach collar						
f. Obtains sputum specimen:						
(1) Expectorated						
(2) Suctioned with mucous trap						
g. Cares for patient with chest tube:						
(1) Assists with insertion						
(2) Discontinues						

RN Critical/Intensive Care

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(11) Cares for patient immediately post-extubation						
k. Cares for patient on BiPAP						
7. Skin Care Procedures:						
a. Provides care for patient at risk for or with actual skin impairment.						
(1) Assesses risk using Braden Scale						
(2) Wound assessment						
(3) Impaired skin integrity report						
b. Performs dressing change:						
(1) Clean						
(2) Sterile						
(3) Wet to Dry						
c. Removes sutures/staples						
d. Maintains/removes wound drains						
(1) Hemovac						
(2) Jackson-Pratt						
e. Collects wound cultures per protocol or M.D. order						
f. Provides care for patient requiring body temperature control with cooling/warming blanket and selects appropriate device per policy.				NPP-W-004 NPP-H-009		
8. Neuro/Ortho Procedures:						
a. Provides care to patient with EVD (external ventricular drain).						
b. Identifies signs/symptoms of stroke/TIA and initiates Code Stroke Protocol as appropriate.						

RN Critical/Intensive Care

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
a. Performs removal of arterial sheath.						
b. Performs removal of venous sheath.						
(4) Post-cardiac Cath without sheath						
d. Provides care for patient receiving cardiovascular medication infusions.						
(1) Verbalizes indications and normal dose ranges for:						
(a) Antiarrhythmics 1.						
(b) Inotropics/vasoactives						
(c) Vasodilators/antihypertensives						
(d) Thrombolytics/anticoagulants						
(2) Calculates & documents infusion rates (mcg/Kg/min or mcg/min) every shift and with changes.						
(3) Titrates medication to achieve desired effects.						
(4) Completes vasoactive drug calculation CAP						
e. Provides care for patient requiring invasive hemodynamic monitoring						
(1) Line insertion						
(a) Bag/pressure tubing set-up						
(b) Monitor set-up						
(c) Patient preparation						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
2. Wedge						
3. Cardiac output/index						
4. SVO_2						
5. Stroke volume						
(e) Prints hemodynamic profile						
(f) Correlates readings with clinical assessment and initiates appropriate interventions						
(g) Verbalizes risks/complications and preventative measures						
(4) Line Removal						
(a) Arterial line						
(b) PA catheter/ $SCV0_2$/flowtract						
(c) Catheter tip culture						
VI. Develops and implements a teaching plan in order to restore, maintain, and promote health.						
A. Identifies survival skills/educational needs of patients.						
B. Reinforces patient education						
C. Documents patient education on Patient Care Pathway/patient education record.						
VII. Evaluates patient response to care and revises plan of care to meet desired patient outcomes.						
In collaboration with preceptor:						

RN Critical/Intensive Care

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
A. Identifies responsibilities of the care manager and other care team members.						
XII. Uses established channels of communication and collaboration to support the achievement of patient and CHI goals.						
A. Communicates effectively with other members of the health care team:						
1. Reports patient status to Care Manager and other team members.						
2. Takes telephone/verbal orders from physician						
3. Gives accurate shift report.						
4. Utilizes patient call system and paging system.						
5. Expresses self in diplomatic manner.						
B. Communicates effectively with patients/families:						
1. Introduces and identifies self to patient/family						
2. Keeps patient/family informed						
3. Recognizes and responds appropriately to patient/family feelings and related behaviors.						
XIII. Actively pursues competency in care manager prerequisites in order to assume the care manager role within the specified time frame as defined by the Clinical Integration Teams.						
A. Registered for Care Management Core Class						
REFER TO GSN TRAINING FOR CARE MANAGER ROLE COMPETENCY ASSESSMENT AND DEVELOPMENT GUIDE.						

Continuation of Orientation Documentation

Utilize this form for documentation of competencies not obtained during initial orientation.

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			

_____

Date & Employee Signature

Reviewed By:_____

Date & Clinical Leadership

Send to Human Resources to be filed in employee's permanent record.

Community Hospital East

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 22

GOVERNING BODY AND MEDICAL STAFF COMMITMENT

"22. **Commitment by the governing body and medical staff:**
There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within 1 year of this application and to achieve ACS verification within 2 years of the granting of "in the process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within 2 years of the granting of "in the process" status that the hospital's "in the process" status will immediately be revoked, become null and void, and have no effect whatsoever."

NARRATIVE RESPONSE AND DISCUSSION

This requirement is met with the attached separately written commitments by the Community Hospital Board of Directors and medical staff to establish a Level III Trauma Center and to pursue verification by American College of Surgeons within 1 year of application to achieve 2 years granting of "In the ACS verification process status.

These letters includes recognition by the hospital that if it does not pursue verification within 1 year of application and/or does not achieve ACS verification within 2 years of the granting of "In the process" status will immediately be revoked, become null and void and have no effect whatsoever.

Community Health Network

Community Hospital East
1500 North Ritter Avenue
Indianapolis, Indiana 46219-3095
317-355-1411 (tel)
eCommunity.com

June 17, 2014

William C VanNess II, MD-Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital East's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The Medical Staff Executive Committee of Community Hospital East endorsed the establishment of a Level III Trauma Center at Community East Hospital. It is our understanding that approval of this application from the Indiana State Health Commissioner will allow any EMS provider to take trauma patients to this facility, thus providing Community Hospital East with the opportunity to receive the patients necessary to demonstrate a record of excellent trauma care.

Furthermore, the Medical Staff Executive Committee understands that if the hospital does not pursue verification within one year of the application and/or does not achieve ACS verification within two years of the granting of "In The ACS Verification Process" status that the hospital's "IN The ACS Verification Process" status will be immediately revoked, become null and void and have no effect whatsoever.

Respectfully,

Scott Vore, MD
Medical Staff President
Community Hospital East

Community
Health Network

June 9, 2014

William C. VanNess II, M.D., Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Application for hospital to be designated "In the ACS Verification Process"

Indiana State Trauma Care Committee:

The Community Health Network Board of Directors endorses the establishment of a Level III trauma center at Community Hospital East. It is our understanding that a favorable approval recommendation from the EMS Commission will allow any EMS Provider to take trauma patients to this facility, thus, providing Community Hospital East the opportunity to receive the patients necessary to demonstrate a track record of excellent trauma care.

Furthermore, the Board of Directors understands that if the hospital does not pursue verification within one (1) year of the application and/or does not achieve ACS verification within two (2) years of the granting of "In the ACS Verification Process" status that the hospital's "In the ACS Verification Process" status will immediately be revoked, become null and void and have no effect whatsoever.

We will provide the leadership and corporate culture to continue to deliver excellent patient care and more specifically demonstrate an exemplary trauma care system to achieve and maintain American College of Surgeons verification as a Level III Trauma Center. Thank you for the consideration of this application.

Respectfully,

Mike Peterson
Chairman, Board of Directors
Community Health Network

MP/jch